Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sylvia Hill <u>10:25</u> P<sup>M</sup> 06/07/2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10110 Glendale Oaks Way Glendale Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours Min 577-44-8559 79 Director 1 □ M 2 🛛 F Yrs. 06/10/1935 DCUsual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location with the Maryland Medical Examiner must be notified at Director 10d. Inside City Limits Prince Georges 1 X Yes 2 No Glendale 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 10110 Glendale Oaks Way 20769 AZU permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò ģ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify 'natural", Completed 3 X Widowed 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Il Hygiene. Own Home HomeMaker Be Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic even once. 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Franklin Gregg Mary Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alethia Simmons / daughter 10110 Glendale Oaks Way, Glendale, MD 20769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Lincoln Memorial Cem. 06/12/2012 Suitland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Strickland Funeral Services . Signa ure / f Funeral Ser/ii / Li /en/ 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Metastatic Pancreatic Cancer Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Litter officer injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed ling physician and eas the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: ttendi use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ō in the past 12 months? Month Day Year ed by the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 tonknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has page 2 s autopsy performed Yes 2 death? eral Director: After this certificate filled in by the funeral director, pag 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 1 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital thin 24 hours at the Funeral I Medical Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier nthua M Dellamo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Williams

Cynthia

4041

Powder Mill Rd., Calverton, MD 20705

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 ear 9:35 Joan Ε. Johnson June 9 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Community Hospital Cheverly Prince George's Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 156-22-8205 81 Director 1 🗆 M 2 🕶 F 10-23-1931 New Jersey 28a-f show 10a. State with the Maryland 10c. City, Town or Location must be notified at 10d. Inside City Limits **Funeral Director** MD Prince George's Forestville 1 X Yes 2 No 10e. Street and Numbe ō 10f. Zip Code 10g. Citizen of What Country? 23a 1913 Overton Drive 20747 United States items 2 · death Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by permit. Page 1 and 2 should be filed within 72 hours after Copartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any njury or other traumatic event, the Medical Examinane, 1 Never Married 2 Married Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify Completed 3 Xwidowed 4 ☐ Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) AT&T Clerical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ William Ware Mattie Merrel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20746 3855 Saint Barnabas Rd Apt/101 , Temple Hills, MD Dreena Shaw ( Niece ) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other-(Specify) Lincoln Cemetery 6/18/2012 | Brentwood, MD . Signature of Fone al Selvi e Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home Luchet Thomas 3401 Bladensurg Rd. Brentwoood, MD 20722 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CARDIAC Physician FAMAL disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or injury that initiated events the burial-tran and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Live in the past 12 months?
1 Yes 2 No Month Day signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown should peen 24a. Was an Were autopsy findings available prior to completion of cause of s certificate has t director, page 2 s autopsy perforn death? 1 Yes 2 No 1 Yes 2x No completely filled in by the funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

Registrar

DHMH 17 Rev 06-2011

3 29b. Signature and title of certi

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registr

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0068294

Cheverly, MD 20785

29d. Date signed (Month, Day, Year)

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20/2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death M/6nth Physician/ Zella May Keenan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Maryland 8. Date of Birth **Funeral** (Month, Day, Year) April 15, 1945 Days Hours 213-44-1663 **Director** 1 M 2 X F Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director LaVale 1 X Yes 2 No Maryland Allegany 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 21502 USA 11 Linda Way permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?, 1 ☐ Yes 2 🖼 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify. "natural", White Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4 or 5+) Office Manager Home Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 May Alice Warnick Ocie Kitzmiller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Linda Way, LaVale, Maryland, 21502 William Keenan - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Datfune 05, cemetery, crematory or other place)
Frostburg Memorial Park 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Frostburg, Maryland 2012 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiacon respiratory arrest Approximate Interval Between Onset and Death 2 A shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical a consequen le **Examiner** noti Sequentially list our ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of Injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury Natural 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

29a. Certifier 1 Lecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
(Check	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated										
only one)	only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. Signature ar	nd title of certifier		29c. License number	29d. Date signed (Month, Day, Year)							

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EMAAN

State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 20 AM Nanay Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Parkville Baltimore Oakcrest Village If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 - X F 92 215-12-1468 1172971919 Mary Land Yrs Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Parkville Maryland **Baltimore** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 21234 USA 8800 Walther Blvd Apt 2503 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 ★Widowed 4 □ Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene ant. If item 27 is marked other than 'ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) School Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Garnett Y. Clark M. Helen Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12750 Indian Field Court, Worton, MD 21678 Fred Kramer - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 X Cremation 3 Removal from State 6/11/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) John M. Taylor Funeral Home 21. Signature of Funeral Service License 22. Name and Address of Facility Myelin , Clot 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or imjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No page 2 should be detached for Day Month Year 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown Records, 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 - N Division of Vital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) 1 Tyes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🔲 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Cartifying Nurse Practioners To the best of my knowledge and title of certifie 29b. Signator 29d. Date signed (Month, Day, Year) 31. Date filed (Month State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Physician/ Marie Kraenter PM 3:15 2013 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Medical entes Anne Social Security Numb 7. Age (In yrs, last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Director 2012 Usual Residence of Decedent 28a-f show 10a, State 10b. County 10c. City, Town or Location ?? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Completed by Funeral Director 1 Yes 2 ☐ No Street and Nu 10f. Zip Code 10g. Citizen of What Country? 0 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Never Married 2 ☐ Married Black, White, etc. Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 N/A and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ra euts ennin Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or 27 permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State CHESAPEAKE CREMATION CENTER 5 ☐ Burial 2X Cremation 3 ☐ Removal from State 6/11/2012 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD Name and Address of Facility LASTING TRIBUTES BY FELLOWS any inj 21. Signature of Funeral Service Licensel FUNERAL CARE CREMATION 23 1 rt 1. Enter the disease, promplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. Us fonly one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ em ( disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicis. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown is certificate has been si director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 2 No Accider
Suicide Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 01 X 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40FF

DHMH 17 Rev 7/2009

State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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,	/		Crofton Care				Croft				Arun	del		
	Funeral Director		5. Social Security Number 6. 219–38–7988		(In yrs. last birth	Months		f Under 24 Hrs. Hours Min.	<ol><li>Date of Birth (Month, Day,</li></ol>	Year)	9. Birthp	lace (State or Foreign try)		
		4	Usual Residence of Decedent	1 M 2 D F	70	Yrs.			05/31/4	+2		imore,MD		
	sho	Þ	10a. State 10b. County		10c. City, Town						10	0d. Inside City Limits		
	Mary	irec	MD Anne Ar	undel	Croft	on						1 ☐ Yes 2 🄀 No		
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	within 72 hours after death with the Maryland giene. giene. er than "natural", or items 23a or 28e-f sho the Medical Exarticet outstoom thin at	Funeral Director	2311 Manomet C				1114			US	3A			
· •	or ite		11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent Ev. Armed Forces?		13. Was Decede If Yes, specif	int of Hispa fy Cuban, N	anic Origin? (Sper Mexican, Puerto F	cify Yes or No- Rican, etc.)		e - America k, White, e			
21215-0036	s afte rai", c	Completed by	3 ₩ Widowed 4 □ Divorced	If Yes, Give	61 <b>-</b> 64	1 □ Yes 2	X No S	Specify:		Specify:	T 17	hite		
5-0	'natu	plet	15. Decedent's (Specify only highest of	Education	16a. I	Decedent's Usual	Occupatio	on		16b. Kind of Bu	usiness/Ind	lustry		
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lan	be file ental l 'ked o ic eve	10	John Kennedy				18	8. Mother's Name Dorothy	(First, Middle, M y Loeff	faiden Surname 1er	)			
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ij	Page 1 tment of tant: if it jury or o		1 ☐ Burial 2 € Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec	Hemoval from State cify)		ic Crema	. ,	06/1	1/2012 G	len Bur	nie,	MD		
Baltimore, Maryland	permit. Page 1 Department of Important: if ii any injury or c		21. Signature of Funeral Service Licer	nsee///										
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	State	•	31. Date filed (Month, Day, Year)	3. Registrar's	Signature				, , , , , , , , ,					
	Registra	r	JUN 12 201	- Cena	A. A	ach								

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Month 06 Physician/ Day 13 2012 **Violet Faye Lewis** РМ 8:33 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett 1740 Old Crellin Road Oakland Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Days Min. (Month, Day, Year) 08/03/1939 Director 218-38-0018 1 □ M 2 😿 F 72 Usual Residence of Decede I 2 should be filed within 72 hours after death with the Maryland the and Mental Hyglene.
27 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Oakland MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21550 **USA** 1740 Old Crellin Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married ☐ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Ulidowed 4 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Construction Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ruby G. Paugh Charles L. Fickes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh tment of Health a tant: If item 27 is jury or other tree Ronald S. Lewis / Husband 1740 Old Crellin Road, Oakland, MD 21550 ltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once, 4 ☐ Donation 5 ☐ Other (Specify) 6/14/2012 Kingwood, WV Sunset Memorial Gardens Crematory Signature of Funeral Service Licenses 22. Name and Address of Facility Burdock-Fredlock Funeral Home, P.A. 21 North Second Street, Oakland, MD 21550 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disea shock, or heart failure. List only one cause on each li Immediate Cause (Final Physician/ disease or condition resulting in death) uear Medical Due to (or as a consequence of) <sup>'</sup>Examiner Sequentially list conditions. Examiner cause (Disease or injury Due to (or as a consequence of) this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-trensit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 1 No 1 🗌 Yes ours after death.

eral Director: After this certifical filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one, examiner? Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Mannet eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral Completely filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: Q ජාම් basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated actitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse only one 29b. Signature and title of confifie 29c. License number 29d. Date signed (Month, Day, Year) D42464 30. Name and sadress of person who completed aus of death (Item 23a) (Type, Print) Sotiere Savopoulos, MD 255 North Fourth St, Suite 100 Oakland, MD 21550 31. Date filed (Month, Day, Year) State

Registrar

JUN 1 5 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:37 A M Angela Karen Long 18 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner Mechanicsville** St. Mary's 40255 Stanley Lane If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 219-96-3000 Director 1 M 2 X F 46 01/16/1966 Maryland Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State Director 1 🗌 Yes 2 🕱 No **Mechanicsville** St. Mary's Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral 20659 40255 Stanley Lane USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event; the Medical Examiner musonee. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Buyer III Government Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lucille Lawrence Thompson Albert Vivian Lyon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40255 Stanley Lane Mechanicsville, MD Stanley L. Long/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Charles Memorial Grds 06/21/2012 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD grature of Funeral Service Licensee Name and Address of Facility Mattingley—Gardiner Funeral Home, P.A. 41590 Fenwick St., Leonardtown, MD 20650 Jan Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Breast Ph\_si\_ian/ metastahi , ears disease or condition Medical resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy Medical Certificate: To Be Completed by

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and s the burial-transit Division of Vital Records, P.O. Box 68760 been signed by the a should be detached f eral Director: After this certificate has filled in by the funeral director, page 2:

with the Maryland

Baltimore, Maryland 21215-0036

255. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year				
Part II. Other significant conditions		Did tobacco use contribute to the cause of death?  1 Yes 2 10 3 Probably 4 Unknown				
		Was an autopsy gridings available prior to completion of cause of performed? Yes 2 No 1 Yes 2 No				
25. Was case referred to medical	26. Place of Death (Check only one)					
examiner? 1  Yes 2 No	Hospital: 1  Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 X	Residence 6 Other (Specify)				
27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Year) injury work? on M 1 ☐ Yes 2 ☐ No	ibe how injury occurred				
3 Suicide 6 Could not 4 Homicide determined	286. Place of Injury - At nome, farm, street, factory, office 281. Locati	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Check 2 Medical Exar	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to to the basis of examination and/or investigation, in my opinion, death occurred at the time, durse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and durse Practitioner:	late and place, and due to the cause(s) and manner stated				

D 50686

29d. Date signed (Month, Day, Year)

18/2012

10 pre

Name and address of person who completed cause of death (Item 23a) (Type, Print)

California Md 20419 Chhabra 23415 Three

Registrar

Funeral

only one) 29b. Signature and title of certifier

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State of	Maryland / E	Department of H Certificate of D	ealth and M		iene eg. No. 2 (	112	205	500		
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Exami	ner		House of St. Ma		Calla				. Mary		- 1		
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vith th	Funeral Director		enbrier Road			0650			USA				
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or it	by	1 Never Married	2 Married 1 Yes	2 <b>X</b> No	1 Yes 2 No		Specify	Whit	te				
permit Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important if item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam	ted	3 🗷 Widowed 4	Divorced Year or Da	tes.	. Decedent's Usual Occup	ation	-	16b. Kind of B	Business/Ind	lustry			
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Page 1 tment of tant: If it		4 Donation 5	Other (Specify)	St. J	loseph's						Α.		
permit. Page Department of Important: If any injury or	OUCE	21. Signature of Funer	aget Lard	mer	22. Name and Address Mai				, MD	20650 Approximate			
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Division of Vital rect  To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director After this certificate ha commiseral villed in by the funeral director, page	0	<u> </u>	Certifying Physician: To the	hant of my knowledge	ne death occurred at the t	ime, date and place	e, and due to the	cause(s) and n	nanner as st	ated.			
Hospi 24 hot. Funer	100	29a. Certifier 1 (Check 2	Certifying Physician: To the Deficient Medical Examiner: On the Deficiency Certifying Nurse Practition	e pest of my knowledgesis of examination and	nd/or investigation, in my op knowledge, death occurred	pinion, death occurre at the time, date and	ed at the time, dat d place, and due	e and place, and to the cause(s) a	d due to the o and manner a	s stated.	ianner sta		
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		30. Name and addre	ess of person who completed c	use of death (Item 23	Ba) (Type, Print)	DS60	cene.	nous	WED	OM O	206		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month dward -arrimore 2000 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours 218-28-5321 **Director** 1 🗓 M 2 🗆 F 81 3/19/1931 Maryland Usual Residence of Decedent 28a-f show Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f s must be notified 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1553 Widows Mite Road 21037 USA 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 X Widowed 4 Divorced Specify: White Year or Dates and 2 should be filed within 72 hours Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Insulator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edward West Larrimore Sr. Alma Lotte Sherbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod Steven Larrimore - Son 216 Helena Drive, Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Page 1 1 XBurial 2 Cremation 3 Removal from State Lakemont Mem Gardens 6/11/2012 4 Donation 5 Other (Specify) Davidsonville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Musel 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) V49 Cancer Medical Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.0. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ res 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 certificate has Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 - No Other: 1 Empatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year, Certificate: 27. Manner of Death 28b. Time of 28c. Injury at hin 24 hours after death. the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State

Registrar

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DHMH 17 Rev 06-2011

of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

12012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Ear1 11:26 A M Robert June May Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Boonsboro Washington 18433 Breathedsville Road 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 22, 1940 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 72 Maryland Jan Director 220-34-2381 Usual Residence of Decedent 28a-f show at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director ms 23a or 28a-f s must be notified Maryland Washington Boonsboro 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 18433 Breathedsville Road U.S.A. 21713 items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Hygiene. other than "natural", or iten rent, the Medical Examiner I 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Service Repair 12 Mechanic permit. Page 1 and 2 should be filed witl Department of Health and Mental Hygier Important: If item 27 is marked other 1 any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles William Evelyn Mae Gladhill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18433 Breathedsville Road Boonsboro, Maryland 21713 Karin L. May/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 06/13/2012 Manor Church Cem. Boonsboro, Maryland Signature of Funeral Service Licer 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA ulu Chan 21713 7606 Old National Pike Boonsboro, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Respiratory disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cimhosin Sequentially list conditions cause. Enter Underlying Exam requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the bunal Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav Pregnant at time of death Other (specify) the 9 Unknown 9 🗌 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy certificate Yes 2 KING Be 25. Was case referred to predical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ 1 Inpatient 2 ER/Outpatient 3 I DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 27. Mann, of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To/fle best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0069527

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JUN 1 3 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WILL ON WILL CUMPUS ROUCH,

Suite 143

Hagerstain MD 217-12

6/20/12 <b>,</b> A	. 7 7	ara Co	State of M	<b>int in Black I</b> laryland / Dep	artment of h	lealth and N	/lental Hva	iene	,		
	777	egathy CO. 1 - State Registrar	Glate of W		ertificate of L			eg. No. 21	012	20512	
		Decedent's Name (First, Middle,	Last)				2. Date of Deat	h	1 [	3. Time of Death	
Physicia		WILLIAM E. MANG	GES				Month 06	16 2	Year 2012	5:30 P. <sup>M</sup>	
Medic Examin		4a. Facility Name (if not institution,	give street and number)		4b. City, Town, o	r Location of Death		4c. County			
<i>J</i>		30 Potomac Str			Cumber			A11	legany	7	
Funeral	Г	,		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp Count	lace (State or Foreign ry)	
Director	Į.	219-54-1747 Usual Residence of Decedent	1 <b>火</b> M 2 □ F	68 Yrs.			05/27/19	944	Mar	yland	
ind show at	5	10a. State 10b. County		10c. City, Town or L	ocation				10	0d. Inside City Limits	
faryla Ba-f s tiffed	ect	MD Alle	egany	Cumber	rland					1 🏋 Yes 2 □ No	
the N a or 2 be no		10e. Street and Number			10f. Zip Code		0g. Citizen of	What Coun	try?		
s 23a	Funeral Director	314 Arch Stree	et	7	21502			U.S.A	١.		
death item	d by Fui	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Spann, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e		
36 after I", or xami		1 X Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	1966	1 ☐ Yes 2 🌠 No	Specify:		Specify		hite	
ours atura cal E	Completed	15. Deceden	Year or Dates.		edent's Usual Occup	pation		16b. Kind of B	usiness/Inc	lustry	
215 1721 an "n Medi	mp	(Specify only highest Elementary/Secondary (0-12)		(Give	e kind of work done o DO NOT use retired)	during most of work	ing	100.74.10	000000000000000000000000000000000000000	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
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filed filed d oth	Be	17. Father's Name (First, Middle, La				18. Mother's Nam			e)		
yla  Ild be Ment	ပ္	Cobern E. Man				Irene	E. Athe	у			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	19a. Informant's Name/Relationsh			ling Address (Street						
e, N and 2 Health em 2; ther t		Mark Manges / 20a. Method of Disposition	Nephew	20b. Place of Disp	199 Fifth				2150		
Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. In moorfant: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Exam once.		1 🕱 Burial 2 🗆 Cremation	3  Removal from State	e cemetery, cre	ematory or other plac	ce)		20c. Location	•		
Iting it. Page ritmer ritmer ritaint nijury	1	4 Donation 5 Other (S			morial Ce		9/2012		erland		
Bal perm Depa Impo any i	13	21. Signature of Funeral Service Li	The Line	1100)	20. Name and Addre	ene St.,					
		23a. Part 1. Enter the deease, or	complications that cause	ed the death. Do not en				-	213	Approximate	
		shock, or heart failure. List of Immediate Cause (Final	nly one cause on each lir	ne.	100		, ,	,		Interval Between Onset and Death	
Physician/ Medical		disease or condition resulting in death)	a. KENA	a consequence of):	CARCIN	MA				ONE YR	
Examiner			Due to (or de	a donisoquoneo oij.							
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rtifica ling p	₩	IF FEMALE:	23c. If yes, outcome								
P.O. Box 68760 that the death certificate b ned by the attending physic edetached for use as the b	ian	23b. Was decedent pregnant in the past 12 months?	1 Live Birth	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	су			ate of delive onth	ery Day Year	
the check	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown		Other (specify) _						
bat th		Part II. Other significant conditio	ns contributing to death	but not resulting in the	underlying cause gi	ven in Part I.	23e. Did tob	acco use conf	tribute to th	e cause of death?	
S, F	d by						1 🗆 Y	es 2 No	3 Prob	ably 4 🗆 Unknown	
ord requ	Completed		Were autop	osy findings available							
e has	l m			-			autops	med?	prior to cor death? 1 \sum Yes	mpletion of cause of	
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Vita ysicia is cer direc	To B	examiner? 1  Yes 2 No	Hospital: 1 ☐ Inpa	tient 2  ER/Outpatie	ent 3 DOA Oth	er: 4 🗌 Nursing Ho	ome 5 E Reside	ence 6 🗷 Oth	er (Specify)	Personal C	
of og Ph ter thi neral		27. Manner of Death	28a. Date of inj	ury 28b. Time o	of 28c. Injur	y at	28d. Describe ho				
Sion ttendir death. stor: Af y the fu	Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	ation			Yes 2 No					
Division of Vital Records, tal or Attending Physician: The law requires rs after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be	erti	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Place of In	jury - At home, farm, si tc. (Specify)	treet, factory, office		28f. Location (St. City or Town		er or Rural	Route Number,	
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physic yetly filled in by the funeral director, page 2 should be detached for use as the bit with the funeral director.											
LA TO ALL	1 /5	(Check 2 Medical E	Physician: To the best of caminer: On the basis of	examination and/or inve	stigation, in my opini	on, death occurred a	t the time, date an	d place, and du	ie to the cau	ise(s) and manner state	
Hosi 24 ho Fune rtely f	edic	only one) , 3  Certifying	Nurse Practitioner: To t	he best of my knowledg				_			
the Hospital ithin 24 hours at the Funeral II ompletely filled	Medical		29b. Signature and title of certifier  29c. License number  29d. Date signed (Mor								
<b>Division of Vital Records, P.O. Box 68760</b> To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Luneral Director. After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the bit.	Medic	29b. Signature and title of certifier	- 11			14016		11/11/	1-7	TH DAIL	
To the Host within 24 hc To the Fune completely i	Medic	29b. Signature and title of certifier	who completed cause of	death (Item 23a) (Type	Print)	14845		IUNE	17	TH 2012	
To the Host Within 24 hc To the Fune To the Fune Completely 1	Medic		who completed cause of	death (Item 23a) (Type,	D - 200	14845 Glenn	Sh Ca	IUNE enchem	17 6m	MD 215	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 Certificate of Death 2. Date of Death Physician/ 9 6:40AM lune Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** HAGERSTOWN WASHINGTON MEDICAL Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 83-20-4630 **Director** 1 X M 2 □ F JANUARY 18,28 PHILA DELPHIA, PA permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? APT 104 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) MACHINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GENEVA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 🗌 Cremation 3 🗌 Removal from State WASHINGTON CROSSINGLO-18-12 NEWTOWN ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility will, And when igna re of Funeral Service Licenses Red 23301 ACCOMAC, 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Renal Physician/ Medical **Examiner** I'm anauy RUCTIVE Esqueritary list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HY Per fersion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed diaseres mellitus 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No REGUIVING 24a Was an performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. mul 40061117 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Merious Medical Daniels rancisco 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 3 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 16 2012 June 6:00 P M Craig Leonard Mellies Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 41890 Green Hills Lane St. Mary's Leonardtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Social Security Number **Funeral** (Month, Day, Year) Months Hours **Director** 513-48-3393 1 X M 2 F 63 01/24/1949 **Illinois** Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location at 10b. County Director must be notified 28a-f 1 Yes 2 No Leonardtown <u>Maryland</u> St. Mary's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5 Funeral 23a 20650 41890 Green Hills Lane death y "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Completed Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha Support Equipment Rework Coordinator U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and coof Health and them 27 is mark. 2 Ruby May Leonard Russell Mellies 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20650 41890 Green Hills Lane Leonardtown, MD Wanda Faye Mellies/ Wife or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Charles Memorial Grds 06/20/2012 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, MD 22. Name and Address of Facility – Gardiner Funeral Home, P.A 41590 Fenwick Street Leonardtown, MD 20650 Signature of Funeral Service License Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1 Approximate shock, or heart failure. List only one cause on e. ch line ediate Cause (Final Interval Between Onset and Death Immediate Cause (Final ETASTATIC SMALL Physician/ CELL LUNG CANCER Medical resulting in death) Mintas Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine Due to for as a consequence of, the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death s after death. I Director: After the 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate; 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide the Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hou To the Fune completely fi

29a. Certifier (Check

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only one)

Signature a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. .

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Registrar

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HOSPITAL

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29d. Date signed (Month,

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POINT LOVKOUT Rd. LEONARD TOWN.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death June 7, Physician/ John M. Martin, II 2012 3:00 A M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Davs Hours Director 505-48-6221 73 Aug. 19, 1938 Washington Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 ☐ Yes 2XX No MD Crofton Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21114 USA 1766 Farmington Court than "natural", or items death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 72 hours after White If Yes, Give Year or Dates. 1959–63 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) CSX Railroad Billing is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Lorna McClean John Martin injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health a item 27 i JoAnn Martin / Spouse 1766 Farmington Ct., Crofton, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State Metro Crematory 6/8/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Juneral Service Licensee 6512 NW Crain Hwy., Bowie, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a Part 1 Enter the vice Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 20 6 Squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k completely filled in by the funeral director, page 2 s autopsy performe Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No 1 🗌 Yes ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Lecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 2012

Registrar

State

31. Date filed (Month, Day, Year)

**JUN 11** 

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 06<sup>Month</sup> Physician/ 16 2012 3:40 P M Mary Formwalt Myers Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Carroll Lutheran Village Healthcare Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Davs Hours (Month, Day, Year) Director 218-07-1409 1 M 2 XF 92 MD 08/07/1919 Usual Residence of Decedent shov 10c, City, Town or Location 10d. Inside City Limits 10a. State the Maryland notified at Director Westminster 28a-f MD Carroll 1 Yes 2 No 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral USA 21157 18 Hickory Ct. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc ò 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 ☐ Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Ames Dept. Store manager - dept. Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Sadie Flickinger Harry Formwalt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18 Hickory Ct., Westminster, MD John Myers/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/21/2012 Westminster, MD Meadow Branch Cemet. 21. Signature of Funeral Service Licensee 22. Name and Addres Prints Funeral Home and Chapel, PA 12 21157 412 Washington Road, Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of **Examiner** Bequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last burial-trar and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Unknown Day Month Year signed by the at the detached for 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown been signated beautiful to the second of the Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 s autopsy perform 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, who completed cause of death (Item 23a) (Type, Print) MIG. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1106 James Gordon Neilson, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Allegany Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 86 September 12, 1925 Maryland **Director** 216-22-5814 28a-f show 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits notified at Director 1 🗌 Yes 2 🗶 No Cumberland Maryland Allegany 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ö 13301 Winchester Road, S.W. must be Funeral 23a U.S.A. 21502ural", or items? death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene item 27 is marked other the other traumatic event, the I **Educational System** Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth L. Bean James Gordon Neilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 20715-Rebecca Neilson Daughter 4514 Oaklyn Ln **Bowie** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State jo <u>∓</u> **5** 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or Maryland Frostburg Memorial Park June 15, 2012 Frostburg 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical 36hCurs Examiner Sequentially list conditions, Examine n any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for use as the buria Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death 4 Pregnant : 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of perform 1 Yes 2 No 1 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examine? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) JUNCS, 2012 28c. Injury at work?
1 ☐ Yes 2 ☑ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 500 PM Natural 5 Pending drove over emborikment Accident Investigation within 24 hours after deati To the Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Windchester Road Cresaitow Medical 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAS 924 Seton Drive, Cumberland MD 21502 Michael Stasko 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nich alson aroline Jeannette 7:271M JUL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Season's Hospice If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours Min. Director 213-40-6067 1 M 2 X F Yrs 02/23/1942 Florida 70 Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No St. Mary's Lexington Park Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 20653 47954 Jackson Run Road 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced USA 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Austin White Caroline Whalen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn C. Nichalson/Husband 47954 Jackson Run Rd., Lexington Park, MD 20653 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Mattingley-Gardiner
Funeral Home, P.A.Crematory 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/21/2012 Leonardtown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick St., Leonardtown, MD 20650 23a. Part/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ LING Concer disease or condition Medical resulting in death) Due to as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year g 🗌 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Pother (Specify) 2 1No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 715 Ray aparumo 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21709 Baltimore NS Rajapak SEMO NID Deme 2835 Smilh AV 5 CO3 31. Date filed (Month 37. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 June 8. 8:45 P M Albert C. Nassif Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Glen Burnie Anne Arundel Baltimore Washington Medical Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min. Director 190-16-1311 90 Yrs 8/21/1921 Pennsylvania permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Annapolis Maryland Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21409 USA 211 Ash Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ð Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify Specify: 3 Widowed 4 Divorced WWII White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self-Employed Businessman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sadie Khoury John Nassif 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1517 Severn Chapel Road, Crownsville, MD 21032 John Nassif - Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Vet Cem 6/13/2012 Crownsville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility John M. Taylor Funeral Home Myclin T. 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTICEMIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 1-3 DAYS CHOL ANGITIS Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events southing in death). Due to (or as a consequence of): Exami ending physician and use as the burial-transit 10-14 DAS or Attending Physician: The law requires that the death certificate be executed CHOLE BOCO LITHIASU Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Lectopic pregnancy in the past 12 months?

1 Yes 2 No ģ Dav Year 5 Other (specify) been signed by the a should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, ATHEROSCLEROTIC CARBIOVASCULAR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? CAMIONYOFATHY 24a. Was an 15 CHEMIC page 2 s has autopsy perform certificate 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Syes 2 □ No ၉ 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death Certificate; 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Investigation 3 Suicide
4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 1 Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the Hosp within 24 hor To the Fune completely fi 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge. Lighth screened at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) / SHAWS 00069146 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1) ANIEL . SHAND MA 301 HOSPITAL DRIVE GLEN BURNE, MY

State

Registrar DHMH 17 Rev 06-2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2135 AM Physician/ Wanda 06 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number Examiner Allegany Cumberland 182 North Centre Street Rear Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth Social Security Number 6. Sex Age (In yrs. last birthday) Werth 27 Year 951 1 M 2 XF 60 218-58-7395 Director Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. Count **Funeral Director** Cumberland MD Allegany 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 182 North Centre Street Rear 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black White, etc. Armed Forces

1 ☐ Yes 2 ☐ No Completed by 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 Yes. Give 3 Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Hospice Home Care nurse 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Laura May Bennett မှ **Hugh Bonnett** 19b. Mailing Address (Street and Number or Rural Route Number, City on Town, State, Zip Code)
7131 Jayhawk Streeet Annandale 19a. Informant's Name/Relationship (Type, Print) son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/6/2012 MD Scarpelli Funeral Home, P.A Cresaptown Donation 5 Other (Specify) 22. Name an Scarpethif Ferriaral Home, PA gnatu 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine eral Director: After this certificate has been signed by the attending physician and filed in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certificate: To Be Completed by 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 4 Nursing Home 5 Residence 6 Other (Specify 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 24 hours after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2.

To the F
complet only one 29b. Signature and title of certif 2012 rson who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 4 3. Time of Death Physician/ Month Day Year Dwight Lamont Pope 11:48 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland 223 Independence Street Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 12/13/1945 1 🕅 M 2 🗆 F Maryland 219-46-0440 66 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director MD Cumberland Allegany 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 21502 USA items 23a 223 Independence Street death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: Completed 3 X Widowed 4 Divorced Black Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Laborer Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Louise Elizabeth and Mental H permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked cany injury or other traumatic evenore. Pope, Sr. Roger Washington ည Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 Terrance L. Pope / Brother 225 Independence Street, Cumberland, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cumberland Crematory 1 Burial 2 X Cremation 3 Removal from State 06/14/2012 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Rome, P.A. of Funeral Service Lo 404 Decatur Street, Cumberland, MD Part 1. Enter the disease or complications that caused the death. Do not onter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence 855,00 burial-transit and Due to (or as a consequence of) resulting in death) Last nding physician ause as the burial Physician/Medical certificate be P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) atten in the past 12 months?

1 Yes 2 No cate has teen signed by the atterpage 2 should be detached for it Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions Intributing to death burnot resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 🗌 No Yes 2 No 1 \sum Yes 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide
4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

Lin

30. Name and address of person who

Nagaratnam

ted cause of death (Item 23a) (Type, Print)

D19318

June 11, 2012

21502

Amend #26, per phy., State of Maryland / Department of Health and Mental Hygiene 06/13/12, nls, Allegany Co. -Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>™</sup>Jun 9. 2012 1:20AM M Physician/ Parsons Sr. Danny Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (if not institution, give street and number) **Examiner** Allegany Cumberland 705 Maryland Avenue If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) PA 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number **Funeral** 1 🙀 M 2 🗆 F Months Hours Feb 144. 1953 219-54-1229 59 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10a. State 10b. Count 10c. City, Town or Location Director Cumberland Allegany MD 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 705 Maryland Avenue permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: white Vietnam Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) self employed contractor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Shirley Mae Klinger မ unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 705 Maryland Avenue Cumberland 19a. Informant's Name/Relationship (Type, Print)
Deborah Parsons wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Termation 3 Removal from State
4 Donation 5 Other (Specify) Scarpelli Funeral Home, P.A. 6/10/2012 MD Cresaptown f Funeral 22. Name and carpenin Furilleral Home, PA Signature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last signed by the attending physician ad be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 des 2 No 3 Probably 4 Unknown in 24 hours after death.

the Funeral Director: After this certificate has been singleted filled in by the funeral director, page 2 should by 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Hesidence 6 Other (Specify, 2 / 10 မှ 1 Inpatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending work?
1 Yes 2 No Accident Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Deturying Priyerotati. To the best of my knowledge, death occurred at the time, date and place, and due to the bases(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) brook Rd, Cumberland, 12,500 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mønth Physician/ Ruthenberg В Dorothy Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Allegany Cumberland WMHS-RMC 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Date of Birth **Funeral** Mov 19, 1920 390-14-0907 Director 1 □ M 2 Ϊ F 91 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count Director Cumberland must be notified MD Allegany 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 23a Funeral 21502 USA 10 N. Liberty St. Apt. 302 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc o. 1 Never Married 2 Married Completed by 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates Specify. white "natural", 3 XWidowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 in and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Majchrzeka မ Frank Horigan Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 527 Washington St. Cumberland 19a. Informant's Name/Relationship (Type, Print) MD 21502 permit. Page 1 and 2 st Department of Health an Important: If item 27 is any injury or other trau Ronald Ruthenberg son 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 2 ☐ Kremation 3 ☐ Removal from State 1 🗆 Burial 6/16/2012 Scarpelli Funeral Home, P.A. MD Cresaptown 4 Donation 5 Other (Specify) eral Service 22. Name ars carpelli Fulleral Home, PA 21. Sign ture o 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ ASPIRATION PNEUMONIA DAYS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🖪 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 잍 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending after death. Director: Af Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral C

completely filled the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

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Jr. MD. 32. Registrar's Signatur

leted cause of death (Item 28a) (Type, Print)

29c, License number

200 Glenn St. Ste. 302 Cu

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ Elwood Francis Riggleman 1015 2012 06 10 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WM Regional Medical Center Cumberland Allegan If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) . Social Security Number **Funeral** Hours Country) 219-03-9997 1 🙀 M 2 🗆 F 92 Director Feb. 9 1920 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director Allegany Lonaconing MD 1 Yes 2 No 10f. Zip Code 10e. Street and Numbe Citizen of What Country? 21539 United States Funeral 17743 Pekin St 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married Completed by ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2XXNo Specify. 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Heavy Equipment College (1-4 or 5+) Operator unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norris ပ္ Bernard Riggleman Delia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12 Island St, Lonaconing, Maryland 21539 Daniel Duncan/friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Rest Lawn Mem Gardens 06/13/2012 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home The 111 Church St, Westernport, Maryland 21562 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset, nd Death Proplete Immediate Cause (Final Physician/ Larcinoma Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi). Examin attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: The law requires that the death Other (specify) been signed by the a should be detached t g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an After this certificate has funeral director, page 2 autopsy 1 Yes 2 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death
Natural
Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 5 Pending 24 hours after death.

Funeral Director: Aft letely filled in by the fur 1 Yes 2 No Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor.

To the Funer

completely file (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi DO0 33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Sunil Gupta, 625 Kent Ave., Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 1 2 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chesapeake Shores Nursing Center Mary's Lexington Park 9. Birthplace (State or Foreign Sex 1 M 2 □ F Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Numbe **Funeral** Days Hours Country Min. Maryland **Director** 88 220-34-3252 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland St. Mary's Lusby 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 631 San Gabriel Road 20657 States United Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛮 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer : If item 27 is marked other or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thorne Norman George Roland Lola Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 1529, Lusby, Maryland 20657 Mary C. Roland- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 06/ 18/2012 Valley Lee, Maryland 4 ☐ Donation 5 ☐ Other (Specify) George Episcopal Signature Juneral Service gicense Edward N. Brins 22. Name and Address of Facility Brinsfield Funeral Home 22955 Hollywood Road, Leonardtown, Maryland 20650 Brins M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia, or respiratory arrest, shock, or heart failure. List only one cau, on each line. Approximate Interval Betwee Immediate Cause (Final -Physician/ disease or condition resulting in death) Medical (or as a conse Examiner Sequentially list conditions, if any heating to immedicause. Enter Underlying Cause (Disease or iinjury Exami The law requires that the death certificate be executed ng physician and as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ atter for u in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death signed by the a d be detached f 9 Unknown 9 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No Records, been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has page 2 s autopsy performed? 1 🗆 Yes 2 🗆 No certificate 25. Was case referred to medical Division of Vital or Attending Physician: 26. Place of Death (Check only one) director, Be examiner? 2 **E** No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) ဂ္ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil this 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1)ene Centennial Street. LaPlata, MD 20646 Alikhani, M.D.A.M. 31. Date filed (Mo) 2. Registrar's Signature State JUN 1 8 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 2<u>012</u> Month Physician/ 3:33 p.m. Richards June Joseph George Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's Hospice House of St. Mary's <u>Callaway</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday **Funeral** Hours 138-20-0738 **Director** 1 X M 2 □ F 12/17/1911 Pennsylvania Usual Residence of Decedent 100 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State Director 1 Yes 2 X No Maryland | St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20650 42201 Riverwinds Drive United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Dept. of Agriculture Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, မ Magdaline Yurgaitis Anthony Richards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20370 White Point Road, Leonardtown, MD 20650 John L. Richards/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or Charles Memorial Cem 06/21/2012 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign have of Theral Surviviensee 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, 20650 22955 Hollywood Road, Leonardtown, MD Jr. M000521 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Jante week Physician/ resulting in death) Medical Examiner Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Month Day Year ed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performed' 2 No 1 Yes Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 ☐ Yes 2 ♠No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending thin 24 hours after death.

the Funeral Director: Afortpletely filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 119/12

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David M. Federle, M.D. 24035 Three No

David M. Federle, M.D. 24035 Three Notch Road, Hollywood, MD 20636

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ 18 1:10 p.m. Raley June Calvin Harry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 44710 Medley's Neck Road Leonardtown Birthplace (State or Foreign Country) If Under 1 Year Months Davs 8. Date of Birth 7. Age (In vrs. last birthday Social Security Number **Funeral** Hours (Month, Dav. Year) Director 578-24-9139 1 X M 2 🗆 F 03/16/1924 Maryland 88 Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location must be notified at the Maryland Director 1 🗆 Yes 2 🏝 No 28a-f Maryland St. Mary's Leonardtown 10f. Zip Code 10g, Citizen of What Country? 9 10e. Street and Number Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event; the Medical Examiner must b any Injury or other traumatic event; the Medical Examiner must b once. 20650 United States 44710 Medley's Neck Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Civil Service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Harry Hamilton Raley Rose Maria Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 44710 Medley's Neck Road, Leonardtown, MD Thelma H. Raley/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State Holy Face Cemetery 06/22/2012 Great Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign and of Pral Service Lines Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ perfensive disease or condition resulting in death) Medical to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to dr as a consequence of) Myelode Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physiciar Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1  $\square$  Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No ျှ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation s after death I Director: A ed in by the f Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Funeral Directory filled in by 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor

To the Fune

completely f only one) 29b. Signature and title of certifier 29c. License number D56261 30. Name and address of pelson who completed cause of death (Item 23a) (Type, Print) 20636 24035 Three Notch Road, Hollywood, MD Archana Gupta, M.D.

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

**JUN 2 1** 

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <u>20</u>12<sup>Year</sup> Physician/ AM Michael W. Ryan, Sr. Jun<u>e</u> 9 2:15 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** (Month, Day, Year) Months 577-52-4919 1 M 2 D F Director Washington, DC 9/20/1937 Usual Residence of Deceden 10d. Inside City Limits 28a-f shov 10c. City Town or Location 10a. State with the Maryland items 23a or 28a-f sho Director 1 X Yes 2 No Prince George's Bowie MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20715 12417 Seabury Lane permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces X Yes 2 No Nat'1 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🔀 No Specify: White If Yes, Give Completed 3 Divorced 4 Divorced Guard Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Cleaning Supplies Salesman Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary O'Hare Daniel J. Ryan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bowie, MD 12417 Seabury Lane, Barbara A. Ryan / Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore, MD 6/13/2012 4 Donation 5 Other (Specify) Beall Funeral 21. Signature of Funeral 22. Name and Address of Facility Bowie, MD 20715 6512 NW Crain Hwy., 1. Exer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ 600 disease or condition resulting in death) Medical Examiner Esquerhially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregna
Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has performe 1 🗌 Yes 2 🗌 No certificate CO 25. Was case referred to medical 26. Place of Death (Check only one) å examiner? Hospital: Other: 2 No ျှ 1 🗌 Inpatient 2 🍱 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 \sum Yes Investigation within 24 hours after death

To the Funeral Director: /
completely filled in by the Accident Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ycertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

2000

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 09 2012 8:30a<sup>M</sup> June Reilly Dennis William Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 8133 Crispin Court Glen Burnie 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **½** M 2 □ F Days Hours Min 09-12-1956 Washington, DC Director 55 577-78-8094 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1X Yes 2 ☐ No Glen Burnie Anne Arundel 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 8133 Crispin Court 21061 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) <u>Building Contractor</u> <u>Private</u> permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Florence Reilly Patrick D. Reilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 Aberdeen Drive Crofton MD 21114 Phyllis Reilly/Sister 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place, 1 Removal from State Lincoln Cemetery: 6/14/2012 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature Funeral Service 3401 Bladensburg Rd Brentwood, MD 20722 23a. Part 1. Enter the diseas. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or liniury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown the P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 AProbably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy has 1 Yes 2 No Director: After this certificate Yes 2 N 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) Hospital 1 Yes Other: 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider work?
1 Yes 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certificants and the Funeral Directors. Division of Vital

Registrar

(Check only one)

DHMH 17 Rev 7/2009

041

ause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2-04281	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Samantha Jo Sv		1- For State	State	of Marylar		artment o		nd Men	tal Hy	_	20	12 20531	
Physicia Medical Exami	an/	Registrar  1. Decedent's Name (First, Samantha	Middle,Las J O	_	eitzer				T	2. Date of Dea Month	Day Year	3. Time of Death 2146 hrs	
)		4a. Facility Name (if not ins	titution, giv	e street and num			4b. City, Town,	or Location of	of Death	June 5, 2	4c. County of D		
Funeral		Peninsula Region  5. Social Security Number	al Medic		Age (In yrs. Ia	ast birthday)	Salisbury If Under 1 Y	ear If Unde	er 24Hrs.	8. Date of Bi	Wicomico	Birthplace (State or	
Director		216-47-8283	1	M 2 XF	15				Min.	-		oreign Country) MD	
Au a		Usual Residence of Deceded			10c. City,	Town or Locat	ion					10d. Inside City Limits	
<b>.</b> .	'n	MD A	llega	ny	L	aVale						1 XX Yes 2 No	
ith the Maryland 23a or 28a-f show	Director	10e. Street and Number	c. C.	ale Dlead	•		10f. Zip Code	1502		1	10g. Citizen of What 0 USA	Country?	
with the		513 George 11. Marital Status		12. Was Deced			s Decedent of i	Hispanic Orig			0- 14. Race - A	merican Indian, Black,	
er death	Funeral	1 Never Married 2 3 Widowed 4		Armed Ford  1 Yes  If Yes, Give Year	es? 2)( No	If Yes, specify Cuban, Mexican, Pue			, Puerto i	Rican, etc.)	White, et		
ours after a sture ours a sture our seture o	d b	15. Decedent's Education		or Dates:	completed)	16a. Deceder	t's Usual Occup	oation (Give I			16b. Kind of Busine		
36 nin 72 ho e. e. then "n dical Es	pleted	Elementary/Secondary (0	)-12)	College (1-4	or 5+)	Stuc	ost of working 1: lent	ITE. DO NOT	use retire	ea)	Educati	.on	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.	Com	17. Father's Name (First, M James M. S	iddle, Last)	039						(First, Middle, Olive)	Maiden Surname)		
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To the Hos within 24 h To the Fur	Medical	one) 2 Medica	Examiner		examination ar		ion, in my opini	on, death occ			and place, and due t	o the cause(s)	
93	Σ	29b. Signature and title of o	ertifier	11)				ose number			29d. Date signed ( June 6, 2012	Month, Day, Year)	
		30. Name and address of po			•			<u>.</u>					
nas	ate	Laron Locke MD.  31. Date filed (Month, Day.)		ant Medical E	xaminer strar's Signatu		Itimore Stre	et, Baltim	ore, M	ID 21223			
Regist		31. Date filed (Month, Day,	2012	Ø	A	Mark.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Dav Donald Leon Sweitzer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Cumberland Allegany Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In vrs. last birthday) Months Hours Director 220-26-7529 1 🕅 M 2 🗆 F 81 10/19/1930 Maryland or 28a-f show 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Flintstone 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20601 Root Road, NE 21530 USA "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗆 No 195
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. , or Completed by 1 Never Married 2 X Married 2 No 1951-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 🗌 Widowed 4 🗆 Divorced White Year or Dates 1953 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) r than ", the Me Elementary/Secondary (0-12) 12 College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other this any injury or other traumatic event; the once. Purchasing Agent Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Simon ပ Joseph Sweitzer Isabelle Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13416 New Oakland Drive, NE, Cumberland, MD 19a. Informant's Name/Relationship (Type, Print) Donald L. Sweitzer, Sr. / Son 21502 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) MD Vet Cem @ Rocky Gap 0611/2012 Flintstone, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the line. Interval Between Onset and Death Immediate Cause (Final Physician/ 515 disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or se a consequence or, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attendion abusinan and the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ page 2 should be detached for in the past 12 months? Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 **X** No 2 No 1 Yes completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of g 29c. License number 29d. Date signed (Month, Day, Year) D0033280 June 8 2012 and address of person who completed cause of death (Item 23a) (Type, Print)
unil K. Gupta, M.D., 625 Kent Avenue, Cumberland, MD 30. Name and address of person. Sunil K. Gupta, 21502 31. Date filed (Mon

Registrar

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Na Donna D.				ter	19b. Mail 1330	ing Address 1 Win	(Street a	and Numb ter	Road,	Route Numb Lot M	er, City o I <b>,</b> La	or Town, St aVale	, MD	2 <b>1</b> 502	
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		23a. Part 1. Enter t shock, or hea Immediate Cause (	rt failure. List	only one c	ause on each	ine.	th. Do not en	ter the mod	e of dying	g, such as	s cardiac d	or respiratory a				Approximate Interval Betwe Onset and Dea	
Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. CONGESTIVE HEART FAILURE  Due to (or as a consequence of):  CORONARY ARTERY DISEASE  Due to (or as a consequence of):															
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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 in the process.	Medical	(Check 2	2 💹 Medical	Examiner:	n: To the best On the basis or ractioner: To t	f examinatio	n and/or inves	stigation, in r	ny opinic	on, death o	occurred at	the time, date	and plac	e, and due	to the cau	use(s) and manne	er stated.
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7		30. Name and addre	ess of person	who comp	Silhin pleted cause o	f death (Item	23a) (Type,	Print)		26907		mb c m³ =		e 6,			
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mopth 2012 DELBERT EARL STRUBE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western MD Regional Medical Center Cumberland Allegany Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) 01/14/1935 Min. Director 215-32-5818 1 XM 2 🗆 F 77 Maryland 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD Allegany Cumber1and 10g. Citizen of What Country? 0 10e. Street and Number 10f. Zip Code items 23a Funeral 17 Paw Paw Way 21502 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. "natural", or permit. Page 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or may injury or other traumatic event, the Medical Examin ang. Completed by 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver 8 Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Strube Elizabeth Starry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Heath / Friend 17 Paw Paw Way, Cumberland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory | 06/19/2012 4 Donation 5 Other (Specify) Cumberland, MD 22. Name and Address of Facility Upchurch Funeral Home, P.A. Sign of Funeral Service 202 Greene St., Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) nuelos Medical Due to (or as a conseque ce of): Examiner Sequentially list conditions, if any, leading to immediate Disect of cross of prosecutions of If any, leading to himedicause. Enter Underlying Cause (Disease or injury Exami that initiated events resulting in death) Last Due to (or as a consequence of): burial-1 physician a Completed by Physician/Medical Hospital or Attending Physician: Tile law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, pege 2 s rould 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to predical 26. Place of Death (Check only one) Be examiner? Hospital မ 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 1 Natural 5 Pending n 24 hours after death e Funeral Director; A eletely filled in by the f Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) Uno 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nas Poonai, M.D. - 924 Seton Drive, Cumberland, MD 31. Date filed (Month, Day Year) 2012 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 11, Day 2012 Physician/ 9:12 PM James Patrick Stewart Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 159 Pine Tree Road Ocean City Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Days Hours Min (Month, Day, Year) Director 577-14-7099 1 □XM 2 □ F 1-2-1921 Wash. 91 DC Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Haath and Mentel Hygiene.
ent. If Item 27 is markad othar than "netural", or Items 23e or 28a-f show ury or other treumetic event, the Marical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ocean City 1 Yes 2 No Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 159 Pine Tree Road 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: white 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Walter Reed Elementary/Secondary (0-12) College (1-4 or 5+) Medical Photographer Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Donald Stewart Josephine Sheara 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Freeman-Daughter 19355 Cypress Ter. Leesburg, VA 20176 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Permit of Permit of Permit of It Ite eny injury or ot on one one of the Permit of the other other of the other other other of the other oth 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) State Crem. 6-13-12 Millsboro, DE 21. Signature of Funeral Service 22. Name and Address of Facility Burbage Funeral Home 108 William Street Berlin, MD 21811 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MALIGNANT LUNG CARCINDONA -Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence of Hospital or Attanding Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should ba detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 27 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home Presidence 6  $\square$  Other (Specify) Hospital: 2 No မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 15+1

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar's Signature

JUN 1 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 <sup>Yea</sup> 12 Physician/ 8:00 Gene A. Stuck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Swanton 298 Glen Cove Road If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Country Aurora Days (Month 6704/1921 91 Director 216-18-1787 1 □ M 2 🛛 F Yrs Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🔀 No Swanton MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 298 Glen Cove Road 21561 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify. Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaking Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hazel Cobun Thomas C. Teets 1 and 2 should be of Health and Me fitem 27 is mark other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 350 Oak Breeze Lane, Oakland, MD 21550 WilliamStuck / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ortant: If if Burial 2 ☐ Cremation 3 ☐ Removal from State 6/11/2012 Oakland, MD 4 ☐ Donation 5 ☐ Other (Specify) Garrett County Memorial Gardens permit.
Departr
Imports
any inju 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Burdock-Fredlock Funeral Home, P.A., 21 N. 2nd St., Oakland, MD 21550 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a Part 1. Enter the disease shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conseque Arc. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending ■ Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Wilbur Z. Sine, 1197 Van Voorhis Road, Morgantown, WV 26505

State Registrar 31. Date filed (Month, Day, Year)

**JUN 11** 

DHMH 17 Rev 06-2011

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Samuel Theron Shank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Fahrney Keedy Nursing Home Boonsboro If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Hours Min 1 × M 2 🗆 F 216-22-8721 Director 85 May 28,1927 Maryland Usual Residence of Deced fshow 10c. City, Town or Location 10d, Inside City Limits must be notified at Director 1 Yes 2 X No Boonsboro 28a-f Maryland Washington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 0 23a Funeral filed within 72 hours after death with USA 21713 8507 Mapleville Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status traumatic event, the Medical Examiner Black, White, etc. ò þ 1 Never Married 2 X Married Yes f Yes, Give 2 No WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Ò Custodian Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mental Hazel E. Myers Samuel W. Shank and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1075 Lindsay Lane Hagerstown, Maryland 21742 t of Health Richard Shank (Son) or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o June 14,2012 Williamsport, MD Greenlawn Mem. Park Other nation 22. Name and Address of Facility Osborne Funeral Home P.A. ture of Fuveral Service 425 S. Conococheague St. Williamsport, MD 21795 . Enter the c sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Fina Ph\_sician/ ment disease or condition resulting in death) Medical ue to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ascular Diseuse (Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last and by the attending physiciar Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) jo in the past 12 months?
1 ☐ Yes 2 ☐ No or Attending Physician: The law requires that the death Month Day page 2 should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 2 No 1 Yes Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Time of 27. Manner of Death Certificate: 28b. 28c. Injury at 28d. Describe how injury occurred s after death. Il Director: After t 1 Natural 2 Accident 5 Pendina 1 Yes 2 No Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) City or Town, State) within 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number -11-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1126 Opal Court Hagerstown, Maryland 21740 Khalid Waseem MD 31. Date filed (Month, I) y (an 💃 🐒 istrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0210 012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner timore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 171-42-3347 1 □ M 2 🔀 F 65 2/8/1947 Pennsylvania ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland of Health end Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Stafford Stafford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 206 Sterling Court 22554 LISA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) home-maker own home 77 is marked other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herbert H. Howell Martha R. Friedman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Danaher, daughter 503 N. Quaker Lane, Alexandria, VA 22304 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Everly Crematory Alexandria, VA 6/20/2012 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Everly Wheatley Funeral Home MO1453 1500 W. Braddock Road, Alexandria, VA 22302 Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STRESS CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate auc. Ensemble 1 Johnson Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 3 Pregnant at time of death Month Year Day q Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu and title of certifi address of person who completed cause of death (Item 23a) (Type, Print) 1800 N. Orleans St Baltimure MD 21287 Antar Hanukka 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death David Raymond Shafer 2012 Jume 20, 6:20 АМ м Physician/ Medical 4b. City, Town, or Location of Death New Market 4a. Facility Name (if not institution, give street and number) 4c, County of Death Frederick Examiner 6455 Boyers Mill Road 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Numb Funeral Days 214-42-1125 Director 1 X M 2 □ F 68 May 1, 1944 Maryland ral", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 💆 No New Market Frederick Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21774 6455 Boyers Mill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1964-1970 Year or Dates: 1 ☐ Yes 2 ☐ No Specify. White "natural". 3 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Technology Customer Engineer Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked oth any Injury or other traumatic event, <u>once.</u> 18. Mother's Name (First, Middle, Maiden Surname) Hazel Zimmerman 17. Father's Name (First, Middle, Last) Harry Raymond Shafer 19a. Informant's Name/Relationship (Type, Print)
Mrs. Sandra M. Shafer, Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6455 Boyers Mill Road, New Market, MD 21774 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Mount Olivet Cemetery June 23, 2012 Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ord PA Funeral Home M00255 106 East Church St., Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ oranary years disease or condition Medical resulting in death) Examiner ears Sequentially list conditions, Due to (of as a consequence of): Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 signed by the ettending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Pregnant at time of death Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 X Yes 2 No 3 Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🕅 No 26. Place of Death (Check only one) **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No |요 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun Accident Investigation 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) June 20, 2012

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State Registrar 31. Date filed (Month, Day, Year) JUN 27 2012 SDIA

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32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June サ, るばる 9:07 Am Silber Ruby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland Lions Center Social Security Number . Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) WV Hours Ƴଫr 30°, 1916 **Director** 213-44-1520 1 □ M 2 🗡 F 95 Yrs 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Allegany MD Cumberland 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral an "natural", or items 23a Medical Examiner must b 21502 901 Seton Drive USA filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces 1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: white Completed 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) the homemaker own home other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F ၉ Lucy Greenawalt permit. Page 1 and 2 should be Dennis Yokum of Health and I 19a. Informant's Name/Relationship (Type, Print)
Gary Silber 19b. Mailing Address (Street and Number or Rural Boute 12101 Scenic Drive NE Number, City or Town, State, Zip Cumberland MD 21502 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of F Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Davis Memorial Cemetery 6/20/2012 Cumberland MD ation 5 Other ( ecify) 22. Name and carpens Furileral Home, PA Sanature Funeral Service 108 Virginia Avenue: Cumberland, MD 21502 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. E Approximate Interval Between shock, or heart failure. List only Immediate Cause (Final disease or condition Atherosclerotic Onset and Death Ph\_sician/ Cardio vascular diseas 2 YEAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of). burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buris **Hospital or Attending Physician:** The law requires that the death certificate be eath nours after death. Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?,
1 Yes 2 No Live Birth Z L recus and Pregnant at time of death this certificate has been signed by the atternal director, page 2 should be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other 2 X No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0055325 who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death June 5, 2012 **Physician** 3:55 PM Bernice Kay Trent /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Grantsville Goodwill Mennonite Home Garrett If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 30, 1940 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 218-50-0659 Pennsylvania Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Grantsville Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with in and Mental Hygiene.
Is marked other than "natural", or items 23a or ? 21536 USA 139 Old Salisbury Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐Yes 2 f Yes, Give 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 X Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant/Bar Bartender 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred June Holler Harry Alvin Trent 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health a 199 Greenville Rd., Salisbury, PA 15558 Harry L. Ringler/PR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Country Side Crematory June 6, 2012 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Nomes, P.A. 21. Signature of Funeral Service Licenses P.O. Box 275, Grantsville, MD luna Nacu 23a. Part1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on healt failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause r inal disease or condition resulting in death) Renal **Physician** FAILURE /Medical Due to (or as a consequence of): BLADDER CANCER Examiner METASTATIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the SS attending p IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed certificate has ဥ After t Certification:

To the Hospital or Attending PI within 24 hours after death.

To the Funeral Director: After it completely filled in by the funeral

								<u>.</u>	24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No
	Was case referred to medical						26. Pla	ice of Death (	Check only one)	
	examiner? 1 ☐ Yes 2 X N	lo	Hospita	ll: 1 □ Inpatient 2 □	ER/Outpatient	3 🗆 🗅	OA Other: 4X1	Nursing Home	e 5 ☐ Residence 6	□Other (Specify)
1 (	Manner of Death 1 XNaturai 2 ☐ Accident	5 ☐ Pending investigation		n. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work?		d. Describe how injury	
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined					ff. Location (Street and City or Town, State)	Number or Rural Route Number,		

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

10003423

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

June 6, 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robin Bissell, 124 Miller St., Grantsville, MD

State Registrar

ca

31. Date filed (Month, Day, Year) JUN 0 8 2012



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene D#23a per PHY State of Maryla 11/2012 AACO HFALIH DEPI. CMH Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death .Day 2012 June 7, Physician/ 11:20 AM Warren Douglas Tennyson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center Birthplace (State or Foreign Country) Social Security Numbe Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Hours 9/17/1942 **Director** 261-68-2974 1**X**XM 2 □ F 69 Illinois Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State Director 1 Yes 2 No Crofton MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21114 2081 Ingleside Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) U.S. Government Senior Accountant other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Wooster Franklin Tennyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21114 Crofton, MD 2081 Ingleside Ct., Charlene Tennyson / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State Lakemont Mem. Gards. 6/15/2012 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beall Funeral Home Signature of Emeral Service Vi ensee Bowie, MD 20715 6512 NW Crain Hwy., disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest tailure. List only one cause on each line. Approximate Interval Between Onset and Death . Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Fina ARDIO PULMONAZ Physician/ disease or condition resulting in death) DIL Medical Due to (or as a consequence of) Examiner CAD Sequentially list conditions. Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by COPD 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has l autopsy performed? death? 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Certificate: To Be examiner? 2.XNo Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Linpatient 2 ER/Outpatient 3 DOA 1 Yes After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending s after death. Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 29b. Signature and title of certifie 29c. License 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2001 Medical Pky., Annapolis, MD 21401 31. Date filed (Month, Day, Year) State Registrar

				ease Type or F State of				<b>k. Ensure</b> Health and	-	_	bie.
		_	For State Registrar			•	tificate of		R	leg. No. 2	112 2054
	Physicia Medic		1. Decedent's Name (First, Mic	Craven		Thoma			2. Date of Deat Month	19 Day	Year 7.03 M
	Examin	er	4a. Facility Name (if not instituted WMHS-RMC		er)			or Location of Death perland	1	4c. County of Alle	
	Funeral Director		5. Social Security Number  238-36-6740  Usual Residence of Deceder	1 🗷 M 2 🗆 F	. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth Month, Pay, May	Ö, 1934	9. Birthplace (State or Foreign Country) NC
	aryland ka-f show ified at	ector	10a. State 10b. Cou		10c. Cit	y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
	with the M 23a or 28 ast be not	Funeral Director	10e. Street and Number Rt 2, Box 10	 )3F			10f. Zip Code	26726		10g. Citizen of W	hat Country? JSA
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ξ	11. Marital Status  1  Never Married 2 K N 3  Widowed 4 Divord	12. Was Decede Arroed Forc 1 1 Yes 2	es? 2 No 1952		Vas Decedent of H f Yes, specify Cub	Hispanic Origin? (Spean, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		- American Indian, , White, etc. <b>white</b>
21215-0036	hin 72 hou ne. <b>than "natu</b> ie Medical	Completed	15. Dece (Specify only hi Elementary/Secondary (0-1	edent's Education ighest grade completed) 12) College (1-4	or 5+)	(Give life. D	D NOT use retired	during most of wor	king	16b. Kind of Bus	rk Police
and 2	should be filed within 73 and Mental Hygiene. is marked other than aumatic event, the Me	To Be C	17. Father's Name (First, Middle Virgil Carl	lle, Last)		Capt	alli		ne (First, Middle, A Sue Barne	Maiden Surname)	IK F OIICE
Maryland	12 should afth and M 27 is mar r traumati	Ì	19a. Informant's Name/Relation Loretta Thoma	onship (Type, Print)	/ife	19b. Mailir Rt	ng Address (Street 2, Box 1	and Number or Ru 03F	ral Route Number, Key	City or Town, Sta	ate, Zip Code) 26726
Baltimore,	Page 1 and 2 s ment of Health a ant: If item 27 i ury or other tra		20a. Method of Disposition  1 ★ Burial 2 □ Cremati 4 □ Donation 5 □ O	ion 3 ☐ Removal from S	20b. F	Place of Dispo emetery, cren nto Menr	sition (Name of natory or other pla nonite Cem	etery	Date 6/18/2012	20c. Location - 0	City or Town, State
Balti	permit. Page 1 Department of Important: If i any injury or once.		21. Signatule of Funeral Selvi		<u> </u>	22		 อิติกิ Fัชก็ĕral I /irginia Avenเ		and, MD 21	502
	Physician/		23a. Part 1. Enter the disease shock, or heart failure. Li Immediate Cause (Final disease or condition	e, or complications that can ist only one cause on each	used the death	h. Do not ente	er the mode of dyi	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
10	Medical Examiner		resulting in death)	Due to (or	r as a consequ	uence of):	Card	ine la	iluma	2	
	cuted nd transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>5</b>	as a consequ			L'			
09	ite be executed hysician and the burial-transit		resulting in death) Last	d.	r as a consequ	uence of):					
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		rth 2  Feta ant at time of c	aldeath 3	Ectopic pregnan Other (specify)	ncy		23d. Date Mon	of delivery th Day Year
s, P.O.	requires that the des been signed by the s should be detached	≥	Part II. Other significant cond	ditions contributing to dea	ath but not res	ulting in the u	nderlying cause g	iven in Part I.			oute to the cause of death?
of Vital Records,	The law requate has beer page 2 shou	Completed							24a. Was ar autops perfor	med? pr	ere autopsy findings available ior to completion of cause of eath?
talF	Physician: The this certificate ral director, paç	a	25. Was case referred to medic examiner?	cal Hospital:		/		Place of Death (Che		Z LE INO	- res 2 - 110
of Vi	ding Physi h. After this o funeral dir	e:	1 Yes 2 No 27. Manner of Death	1 🗆 In	injury	28b. Time of	28c. Inju	ry at	ome 5 Reside		
ion	l or Attending after death. Director: After in by the fune	Certificate:		estigation	Day, Year)	injury		k? ]Yes 2 ☐ No			
Division	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completely filled in by the fr		4 Homicide det	termined 28e. Place of building	, etc. (Specify	")	eet, factory, office		City or Town	, State)	or Rural Route Number,
	the Hosp nin 24 hou the Fune npletely fi	Medical	(Check 2   Medic opty one) 3   Certify	ying Nurse Practitioner: 7	of examination	n and/or invest	igation, in my opin	ion, death occurred	at the time, date an	d place, and due t	to the cause(s) and manner stated
	2 MA		29b. Signature and title of cert	ifier / Ned	Morel	ony	Dicens	of SOS	3	9d. Date signed	(Month, Day, Year)
	10 14.		30. Name and address of pers	son who completed cause Kayiyu	of death (Item	1 23a) (Type, F	Setz	in Driz	re Cu	mes	land, MRO)
	Stat Registra		31. Date filed (Month, Day, Yea	012 6 32. Reg	gistrar's Signat	ture	,				7

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month. Physician/ 1029 2012 Hattie B. Wise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula Regional Salisburu Dicamica medical Center Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min. Hours Country) Director 1 □ M 2 🕱 F MD 230-50-4097 Usual Residence of Decede 10/10/1941 70 Yrs. item 27 is merkad other then "neturel", or items 23e or 28e-f ehow other treumetic avant, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filad within 72 hours after death with the Maryland Director 1 Yes 2 2 No Horntown Accomack VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23395 USA 3525 Coldcall Rd 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 N Divorced Specify. Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pege 1 and 2 should be filad within 72 h Department of Haalth end Mental Hygiene. Importent: If Item 27 is merkad other then "nt eny injury or other treumetic avant, The Madis once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Poultry Laborer ae 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Marshall George Bonniville 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hillary Wise / Son P.O. Box 50, Horntown, VA 23395 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3 Removal from State Burial 2 Cremation Mt Sinai Cemetery 6/16/2012 Pocomoke, MD 4 Donation 5 🗖 Other Si nature of Fun 22. Name and Address of Facility Cooper & Humbles Funeral Co., Inc., Accomac, VA 23301 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a. Part 1. Enter the Approximate Interval Between Onset and Death shock, or heart failure. List Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): 24 hours after death. I have certificete has been signad by the attending physician and I Funerel Diractor: After this certificete has been signad by the attending physician and etally filled in by the funerel diractor, page 2 should be detached for use as the burial-transit Hospitsi or Attanding Physicien: The lew raquires that tha death certificate be executed Due to (or as a consequence of): Physician/Medicai Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an performe 1 🗌 Yes 25. Was case referred to ledical å 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 W Natural 1 Yes 2 🗌 No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medicai 29a. Certifier 1 **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completaly Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 1 32. Registrar's Signature State **JUN 13** 

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 5:45 AM Wheeler Ashby June 8. James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's 6812 Parkwood Street Hyattsville 8 Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 233-44-7545 1 X M 2 □ F Director Jan. 27, 1930 West Virginia Usual Residence of Decedent show 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 ¥ Yes 2 □ No Prince George's Hyattsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20784 6812 Parkwood Street USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 1 151 1 -13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 951 If Yes, Give 1953 Year or Dates 1953 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify White 3 X Widowed 4 ☐ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Secondary (0-12) Painting Contractor Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ည James A. Wheeler Bessie Kiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a item 27 i Kenneth Woodring/ Executor 4113 Great Oak Road Rockville, MD 20853 or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ot Page 1 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 6/15/2012 Brentwood, MD 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licen-16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last the burial-tran attending physician I for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 L Fetal uea
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the at be detached for g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy page 2 performed Yes 2 After this certificate or Attending Physician: after death. 25. Was case referred to medical the funeral director, To Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5 X Residence 6  $\square$  Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death. ☐ Accident ☐ Suicide Investigation Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral Completely filled the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

VP

State

29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

MID

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Date Month 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 708 Dill Road Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Davs Hours (Month, Day, Year) 216-64-1321 **Director** Yrs 11/11/1953 58 Washington, DC item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Severna Park Maryland Anne Arundel 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 708 Dill Road USA 21146 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: 3 Divorced 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) 12th College (1-4 or 5+) Consultant Restoration Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any jointy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Whittles Marion Catrambone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Whittles/ Wife 708 Dill Road, Severna Park, Maryland 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Kalas Crematory 6/9/12 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Doset and Death Immediate Cause (Final Physician/ OTNOCER disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Due to lor as a consequence of signed by the attending physician and d be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s after death.

I Director: After this certificate has autopsy performed? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify, 1 Yes 2 1110 Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) ertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number ted cause of death (Item 23a) (Type, Print) Day, Year) 32 Registrar State Registrar

DHMH 17 Rev 06-2011

Maryland 21215-0036

Box 68760

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 135 PM Addie Watts Tune 2012 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore WAShington Anne AC GIEN Medical Center Burnie 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) If Unde Birthplace (State or Foreign Country) **Funeral** 214-24-9619 83 Director 1 - M 2 X F 08/19/1928 Maryland 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Gambrills 1 Tes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 968 Annapolis Road 21054 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or it any injuy or other traumatic event. the New York once. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 08 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Herschel Turner Grace Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Watts 529 Carol Ave Gambrills,MD 21054 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or of Church of God 06/12/2012 Gambrills,MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A.Gambrills, MD 21054 2.0 3 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ As DICATION Neumoni disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) for in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 Director; After this certificate 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 Yes filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Insertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hor To the Fune completely fi 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b, Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 Hospital Baltimure MI 31. Date filed (Month Day, Year) JUN 12 2012

DHMH 17 Rev 06-2011

Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral		5. Social Security Num	nber 6. Sex	× T	7. Age (In yrs. I	ast birthday)	If Under 1 Year	If Under 24Hrs	_	rth (MM/DD		Birthplace (State or
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Division of Vital Records, tal or Attending Physician: The law requirers after death.  In Director: After this certificate has been sited in by the funeral director, page 2 should be in by the funeral director, page 2 should be in by the funeral director.	위	1 Yes 2 27. Manner of Death	No	28a. Date		28b. Time of In		at Work?	28d. Describe	how injury	occurred	
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical			and manner st					, , , , , , ,			fonth, Day, Year)
	Σ	29b. Signature and title	a or certifier				29c. License					ionin, bay, rear,
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$\varphi$	Ì	30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti. MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223										
	_	Donna M. Vind	centi, MD	Assistant M	ledical Exar	miner 900	v. Baltimore (	Street, Baltin	nore, MD 2	1223		
Sta		31. Date filed (Month,		32. Re	gistrar's Signati		,					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 20548 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Monthe William Brown Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Jown, or Location of Death 4c. County of Death HGNU S HOSPITAL ALTMORE n/a 6 Sex If Under 24 Hrs. Birthplace (State or Foreign Country) Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 213-20-0045 1 🔀 M 2 🗆 F 87 Director March 14,1925 Maryland Usual Residence of Deceden or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 ☐ Yes 2 🕅 No Maryland Anne Arundel Brooklyn Park 10e. Street and Numbe ems 23a or r must be n or 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 USA 424 Old Riverside Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, than "natural", or iter ne Medical Examiner Black, White, etc à 1 Never Married 2 Married 1 Yes 2]
If Yes, Give
Year or Dates Baltimore, Maryland 21215-0036 within 72 hours after Specify: White 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with.
Department of Health and Mental Hygiene Important: If item 27 is marked other th: any njury or other traumatic event, the <u>once.</u> the 9 Allen Shoe Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle McKnew William K. Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Morris/daughter 424 Old Riverside Road Brooklyn Park, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 06/28/2012 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service License Stephanie Custer 22. Name and Address of Facilit Cremation Society of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line set and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) and burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical  $LJ/c\partial LU/U$ , LU/LU/HMUDivision of Vital Records, P.O. Box 68760 the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 Yes Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other 1 Yes 2 The မ 1 Inpatient 2 EB/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? Natural Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifier 66108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Isaiah Leon Bolton 21 2012 1020 Δ Medical June 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Montgomery Silver Spring . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours **Director** 1**X**□ M 2 □ F 570 579-46-6323 Usual Residence of Decedent Yrs 12/20/1938 73 Washington, DC or 28a-f show notified at 10a. State irector 10c, City, Town or Location 10d. Inside City Limits Silver Spring 1X Yes 2 □ No MD Montgomery ō 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral 13224 Trebleclef Lane 20904 USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces? Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) I Hygiene. BS Equal Opportunity Spec Federal Government Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louis Bolton Sarah Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 Roslyn Bolton - Wife 13224 Trebleclef Lane; Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/29/2012 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem PK. Landover, MD 22. Name and Address of Facility Freeman Funeral Services ure Funer I Trvice Lic Ins. e 4594 Beech Road; Temple Hills, Maryland, 20748 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence on Examin Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been a 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? death? this certificate To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA s after deaun.
al Director: After this of all of the funeral of 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 V Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed Month, Day, Year, 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#3perpHYS, G929, 77272012 WS
State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 0 7 4 1 PAM Physician/ Mont BRAGER Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death <u>Anne Arundel Medical</u> Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs Hours **Director** 219-22-9955 1 🔀 M 2 🗆 F 83 Oct. 26,1928 Maryland 23a or 28a-f show st be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 U.S.A. 8451 Garden Road "natural", or items edical Examiner mu 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces Black White etc. Completed by 1 Never Married 2 Married 2 □ No 1951-1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Divorced 4 Divorced 1953 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) N/A Elementary/Secondary (0-12) other traumatic event, the 8 Iron Worker Local 16 Be 17. Father's Name (First, Middle, Last) and Mental H 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter Brager Sophie Jankowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mildred A. Brager (Wife) 8451 Garden Road Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Pk. 06/29/2012 Elkridge, Maryland Signature of Juneral Service Licensee 22. Name and Address of Facility MOO-732 McCully-Polyniak Funeral Home P. A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner IRIMMY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Dav signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 No certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No ျ Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death I hours after death. uneral Director: After thely filled in by the funera 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and the of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFOUSE -UKAS inp HIGHWAY 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

mend #8 Per FH G929 7/13/2012 JH
State of Maryland / Department of Health and Mental Hygiene 20 | 2 State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Mary Theresa Broullire 2012 20 P M Ju<u>ne</u> 5:45 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Renaissance Gardens Silver Spring Montgomery 5. Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 1918 9. Birthplace (State or Foreign Country) **Funeral** Days Months Hours 578-18-0593 Director 94 1928 Massachusetts Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director MD Montgomery Silver Spring 1 🗆 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3160 Gracefield Rd., ET2101 20904 USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Timothy Sullivan May Quimby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau John Christopher Broullire/Son 11510 Deborah Dr., 20854 Potomac, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 7/10/2012 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signature of Funeral Service Lice Isee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heapfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arteriosclerotic cardiovascular disease ye<u>ars</u> disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) Exami and -trans Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23h Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 X No been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖔 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autonsy Hospital or Attending Physician: The 1 Yes 2 No Yes 2X No After this certification funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 4 □ Nursing Home 5 □ Residence 6 ₺ Other (Specify) Asst. Lvg. 1 🗌 Yes 2 🗓 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🖺 Natural injury w<u>ork</u> 5 Pending in 24 hours after com-he Funeral Director: Aft maked filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Julíane Harding, 20904 NP3110 Gracefield Rd., Silver Spring, MD

State

Registrar

31. Date filed (Month, Day, Year)

JUN 28 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Per TNP G938 4/10/2013 JH State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Louise Vera Benner 2012 11:59 P M June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore Social Security Number 184-23-9567 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 80 Director 1 M 2 X F 08/20/1931 Pennsylvania Usual Residence of Decedent permit. Page 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be natified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3010 Greenway Drive 21042 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. è 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White If Yes, Give Completed 3 ₩ Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frank Fertig Helen Ε. Weikel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Myra Wieman / Daughter 8297 Elko Drive, Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 06/27/2012 Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Ucensee Connelley Dr. Ste. P. Hanover, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin anding physiclan end use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical レシム おとっつをし Division of Vital Records, P.O. Box 68760 attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 9 Unknown 5 Other (specify) signed by the at id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ᅙ 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been si sfuneral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: B B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending ours after death. ieral Director: Aff filled in by the fu 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 MCCertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certiff 29c. License number completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State JUN 28 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Georgia Louise Bryant June 24 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Columbia Howard Brighton Gardens of Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 220-20-2336 Director 1 □ M 2 🗓 F 84 12/04/1927 Ohio Usual Residence of Decedent 28a-f show 10a. State 10c. City. Town or Location notified at Director Howard Columbia MD 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a o Funeral U.S.A. 7110 Minstrel Way, 21045 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 K Married ☐ Yes 2 🔀 No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced er than "natur , the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home Ith and Mental Hygier

27 is marked other t

traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Page 1 and 2 should be ment of Health and Menta Albert Thompson Hazel Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 8512 Wild Wing Way, Columbia, MD 21045 Rebecca Fredrickson/Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 06/26/2012 Hanover, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ☐ Live Birth ∠ ☐ 1 e.a. ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b director, page 2 s autopsy death? 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Hospital or Attending Pl 24 hours after death. Funeral Director: After the 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation
6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

11:34P

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

6-25-12

Columbia, MD 21044

Year

1 X Yes 2 No

P.O. Division of Vital Records,

State

(Check

29b. Signature and title of certifier

10710 Charter Dr., Ste G020 Knight Clement B. MI) 31. Date filed (Month, Day, Year) JUN 2 8 2012

son who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

	X-	on AKA Anthony Gillman	
·04765 k Unk		Please Type or Print in Black Indelible Ink. Ensu State of Maryland / Department of Health a	
		1- For State Certificate of Death	and Mental Hygiene 2012 2051
Physicia edical Examin		1. Decedent's Name (First, Middle, Last)  Property A A A A A A A A A A A A A A A A A A A	2. Date of Death Month Day Vear Une 25 2012  2. Date of Death Apple 1 3. Time of Death 0449 hrs
1		4a. Facility Name (if not institution, give street and number)  4b. City, Town,	or Location of Death June 25, 2012 U449 hrs
		Peninsula Regional Medical Center Salisbury  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y	
Funeral Director			/ear If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
ь		Usual Residence of Decedent	
ld how any	L	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits  1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip Code	e 10g. Citizen of What Country?
th the l		4212 Nadine Drive =	21215 USA
eath wi	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cub	Hispanic Origin? (Specify Yes or No- pan, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
after d	by Fu	3 Widowed 4 Divorced if Yes, Giva Yeer or Dates:	
2 hours		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occup during most of working li	pation (Give kind of work done life. DO NOT use retired) 16b. Kind of Business/Industry
nthin 7.	Completed	12 0 Truck	Driver Commercial
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		17. Father's Name (First, Middle, Last)	18.Mother's Name (First, Middle, Maiden Surname)
212 ould be 1 Ments in mark	To Be	19a. Informant's Name/Relationship (Type, Print) Mother) 19b. Mailing Address (Str.	reet and Number or Rural R: Ite Number, City or Town, State, Zip Code)
MD and 2 sho atth and 27 is 7 is aumanti		Mrs. Shirley Cain 14212 Nac	line Dr. Baltimore, MD 21215
Baltimore, Dermit. Pages I an Department of Hea Important: If iter		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of correlatory or other place)	cemetery, Date 20c. Location - City or Town, State
Baltim permit. Pa Departmen Important injury or o		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee  22. Name and Addre	Park 630 12 Wold Run MD
E P P I		Tatelle F. Harris & M. 2222 W	. North Ave. Balto. Mp 21216
Physician // Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyin- failure. List only one cause on each line.	ng, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner	ļ	Immediate Cause (Final disease or condition resulting in death)  a Anaphylactic Reaction  Due to (or as a consequence of):	Deau
	2	Sequentially list conditions, if any, leading to immediate	
	camin	cause. Enter Underlying Cause (Disease or injury that initiated	
		d.	
be exection a sician a nurial -	dica	☐ AMENDED 23a,27,28a-f,per me,g9	929 7-27-12 sm
Division of Vital Records, P.O. Box 68760, ctal or Attending Physician: The law requires that the death certificate be extra after death.  1 Director: After this certificate has been signed by the attending physician led in the funeral director, page 2 should be detached for use as the burial.	Physician/Medical E	FEMALE: 23c. If yes, outcome of pregnancy   1 Live birth 2 Fetal death 3	23d. Date of delivery  B Ectopic pregnancy Month Day Year
OX 6	Sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown	
O. B at the de lby the tached 1		Part II. Other significant conditions contributing to death but not resulting in the underlying cause	e given in Part I. 23e. Did tobacco use contribute to the cause of death?
J. P. nires that is signed do be de	ă b		1 Yes 2 No 3 Probably 4 Unknown
aw requast beer 2 should	Completed		24a. Was an autopsy findings available prior to completion of cause of
Rec : The l ficate l			performed? 1 Yes 2 No 1 Yes 2 No
Vital ysician his cert directo	o Be	25. Was case referred to medical examiner?  1 Very Yes 2 No  Hospital: 1 Inpatient 2 Very ER/Outpatient 3 DOA	ce of Death (Check only one)  Other Nursing Home 5 Residence 6 Other:
ding Ph After th funeral	⊢ŀ	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Inj	jury at Work? 28d. Describe how injury occurred
Attend Attend r death ector: by the	catic	2 X Accident Pending Investigation   fd 6-25-12   fd 4:00 am   1	
Division pital or Attencours after death eral Director: filled in by the	Certification:	Suicide 4 Homicide  6 Could not be determined  Copecify) Found: In Cell	or Town, State) ECI, DOC, 30420 Revels Neck Rd. Westover, MD.
		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, of	date and place, and due to the cause(s) and manner as stated.
To th within To th compl	Medical	2 Medical Examiner: On the basis of examination and/or investigation, in my opinio and manner stated.  29b/Signature and title of certifier 29c. Licen	on, death occurred at the time, date and place, and due to the cause(s)  se number 29d. Date signed (Month, Day, Year)
	-		C.M.E. June 26, 2012
	ŀ	O: Name and address of person who completed cause of death (Item 23a)	
	- 1	Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street	et, Baltimore, MD 21223
Stat		21. Date filed (Month, Day, Year)	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	1 _ State	ryland / Depa	artment of F tificate of D			0.01	0 00000
			Registrar  1. Decedent's Name (First, Middle, Last)	Cer	uncate or L	)Galli	2. Date of Dea	Reg. No.	3. Time of Death
	Physicia Medic		ALICE BROWN				Month O 6	Day Year 201	2,10,0
	Examin	er	4a. Facility Name (if not institution, give street and number)  RELITION WOODS OF FR.	ALVERA		Location of Death	=	4c. County of Dea	ith
مريد	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	h 9. Bi	TIMORE rthplace (State or Foreign
	Director		184-22-4676 1 □ M 2 🖁 F	91 Yrs.	Months Days	Hours Min.	June 1	1921 Co	ountry) Virginia
	how at	۱	Usual Residence of Decedent  10a, State 10b. County	10c. City, Town or Loc	cation				10d. Inside City Limits
	farylar 8a-f s tified	Director	MD	Balti	more				1 X Yes 2 ☐ No
	a or 2 be no		10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	th with ms 23 must	Funeral	3210 Harford Road  11 Marital Status 12. Was Decedent Ev		Mas Dasadant of Li	21218	ogify Voc or No	USA	
980	s filed within 72 hours after death with the Maryland tal Hygiene.  ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Every Armed Forces?  1 □ Yes 2 ▼ If Yes, Give Year or Dates.	lo	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🎇 No		Rican, etc.)	14. Race - Ame Black, Whi Specify: <b>b1</b>	te, etc.
21215-0036	nin 72 hou ne. <b>than "natu</b> <b>e Medica</b>	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5-4)	(Give I	dent's Usual Occup kind of work done o O NOT use retired)	during most of work	ing	16b. Kind of Business	
27	filed withir al Hygiene d other tha	Be C	unk unk  17. Father's Name (First, Middle, Last)		domesti unk		e (First Middle I	private  Maiden Surname)	homes
land	be file ental I rked o ic eve	입	Tr. Tadio 3 Name (r. 15t, Imadie, 200)		unk		Gholson		
Maryland	1 and 2 should be filed f Health and Mental H item 27 is marked ot other traumatic ever		19a. Informant's Name/Relationship (Type, Print)					; City or Town, State, Z	ip Code)
	and leal leal sm 3		Mary Ann McManus/daughter  20a. Method of Disposition		Harford				w Taura Chata
Baltimore,	permit. Page 1.a Department of H Important: If ite any injury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state		natory or other plac	ee)	Date	20c. Location - City o	r Iown, State
Bal	permit Depar Impor any in		21. Signal of Funeral Service Licenses Wade, Dire	etor St Ba	iltimore,	omy Board MD 2120	)1	Baltimore	Street
			23a. Part Enter the disease, or complications that caused shock or heart failure. List only one cause on each line.	the death. Do not ente				est,	Approximate Interval Between Onset and Death
and the	Physician/  Medical		disease or condition	CONSEQUENCE OF):	O VE	MENT			
-	Examiner	_	Sequentially list conditions, b.		TON	PNEU	MONI	A	
	p #	nine	if any, leading to immediate cause. Enter Underlying	consequence of):  REBROV	10111	D	20000	· -	
	xecute and al-tran	Exar	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a	consequence of):	HS CO G	4R 1/2	-SEHS		
092	icate be executed physician and s the burial-transit	edical Examiner	d						
876	rtificat ing ph e as th		IF FEMALE:				<del></del>		
. Box 68	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1   Yes 2 No 9   Unknown	Fetal death 3	Ectopic pregnand Other (specify)	cy		23d. Date of de Month	elivery Day Year
s, P.O.	ires that the signed by do be deta	d by PI	Part II. Other significant conditions contributing to death but DTABETES MEULTTU			ven in Part I.		obacco use contribute t	o the cause of death?  Probably 4 Unknown
Division of Vital Records,	The law requ	Completed by	HYPERTENSION, 1			NTRACTURE	perfor	osy prior to death?	utopsy findings available completion of cause of
al R	ician: The certificate rector, pag	Be C	25. Was case referred to medical		26. PI	ace of Death (Chec		2 No 1 ☐ Y€	es 2 No
Ζ	hysici his ce al direc	은		nt 2 ER/Outpatier		4 Nursing Ho		lence 6 Other (Spe	cify)
on of	ending P eath. or: After t he funera	Certificate:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		work		28d. Describe h	ow injury occurred	
Divisi	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director. After this completed filled in by the funeral di	al Certi	4 Homicide determined 28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Number or Ri n, State)	ural Route Number,
	n 24 hou n 24 hou ne Funei	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of results of the basis of examiner: On the basis of examiner: To the basis of e	amination and/or inves	tigation, in my opinio	on, death occurred a	t the time, date ar	nd place, and due to the	cause(s) and manner stated.
_	To the withing the complete co		29b. Signature and title of certifier		29c. License	e number	-,	29d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who completed cause of de	ath (Item 23a) (Time 5	Print)	101335	>4	6/18/	2012
			ARON RAGHUNATHMO	3813 WACT	HAM W	DODS RO.	4204 Px	ARKUILLE	M 21234
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registral	's Signatur	arked				s stated.  11, Day, Year)  2012  M 21234

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #55tae Be Manan Decarment of Health and Mental Hygiene

idy Biair		1- For State OF Maryland 7 Department of Health and Mental Hygiene Certificate of Death Reg. No.	2012 2055
Physicia edical Exami			Year 3. Time of Death 1950 hrs
			ounty of Death  Itimore County
Funeral Director		5. Social Security Number un k6. Sex 1. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/ Months Days Hours Min. Jan 22, 193	YYYY) 9. Birthplace (State or Foreign CountryKentucky
and show any acc.	or	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   Rosedale   10b. County   10c. City   Town or Location   10c. City   10c. City	10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 23a-f show must be notified at once.	I Director		of What Country? USA
	by Funeral		Race - American Indian, Black, White, etc.  ecify: white
5-0036 ted within 72 hours after Hygiene. other than "natural",	Completed b		of Business/Industry
MD 21215-0036 d 2 should be filed within 7 tth and Mental Hygiene. n 27 is marked other than numatic event, the Medical	Be	Ora Blair Viola Littrell	name)
2 2 2 2	٩	Andy Blair Jr/son P.O. Box 116 Abingdon, MD 21009  20a. Method of Disposition Disposition (Name of cemetery, Date 20c. Local	
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in state 21. Signature Funeral Serice Licenses 22. Name and Address of Facility State Anatomy Board 655 W. Bal	
Physician /Medical Examiner		23a. Pat I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, failure List only one cause on each line.  Immediate Cause (Final disease  a. Hypertensive Atherosclerotic Cardiovascular Disease	or heart Approximate Interval Between Onset and Death
	Examiner	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
60, tte be executed hysician and e burial - transit	cal Exan	events resulting in death) Last  Due to (or as a consequence of):  d.  UNPENDED  VAMENDED  AMENDED  AMENDED  Due to (or as a consequence of):  d.	
leath certifica e attending pl		FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   1   Unknown   2   Tetal death   3   Ectopic pregnency   More than 12   Specify   2   Other (Specify)   3   Unknown   2   Tetal death   3   Ectopic pregnency   More than 2   Tetal death   3   Ectopic pregnency   More than 2   Tetal death   3   Ectopic pregnency   More than 2   Tetal death   3   Ectopic pregnency   4   Pregnant at time of death   5   Other (Specify)   9   Unknown   9   Unknown   9   Unknown   1   1   1   1   1   1   1   1   1	ate of delivery nnth Day Year
P.O. es that the signed by be detach	至	Renal disease	contribute to the cause of death?  o 3 Probably 4 V Unknown
of Vital Records, R. Physiciae: The law requir the this certificate has been sneral director, page 2 should	Completed	24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No
Vital Recysiciao: The his certificate director, page	a	25. Was case referred to medical 26. Place of Death (Check only one)  examiner?   Hospital:	6 Other:
_ = ₹ , <sup>3</sup> ≥	tion: To	27 Manner of Death 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury of	
Division  To the Hospital or Atteodii within 24 hours after death.  To the Fuoeral Director: /	Certification:	Accident Investigation  3 Suicide 6 Could not be determined Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	Number or Rural Route Number, City
the Hos hin 24 h the Fug npletely	Medical		
To witi	Mec	29b. Signature and title of certifier  29c. License number  29d. Date  O.C.M.E.  June 8	e signed (Month, Day, Year) I, 2012
		30. Name and address of person who completed cause of death (Item 23a)  Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
St Regist	ate		

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Sharon Lee Baseman :00P M 2012 Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare-The Pines Talbot Easton Social Security Number If Under 8. Date of Birth Sept 19. 1943 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours 217-42-5383 Maryland Director 68 Usual Residence of Decedent 28a-f shov ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21601 USA 610 Dutchmans Lane 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 🌠 No 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. white 3 Widowed 4X Divorced Specify. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) housewife own home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Samuel Henry Singleton Georgia Lucille McClarey permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Walters/niece 11158 Tuckahoe Road Denton, MD 21629 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Sig late of Funeral Service Rona L State Anatomy Board 655 W, Baltimore Street Baltimore, MD 21201 Director 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final √Ph√sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Pregnant at time of death Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 0 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to edica Be 26. Place of Death (Check only one) examiner? Other ျဉ 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 eral Director: After this certificate I filled in by the funeral director, pag within 24 hours a

To the Funeral C

completed filled

> State Registrar

Medical

29a, Certifie (Check

29b. Signature

Date filed /\Lambda

determined

and title of certifier

32. Registrar's Si

City or Town, State)

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Busick Physician/ Emma Month 06/25/2012 08:43a <sup>M</sup> Medical la. Facility Name (if not institution, give street and number) 308 Chestnut Rd. **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Linthicum Anne Arundel . Social Security Number 6 Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Min. 80 Country) MD 216-28-1223 0271871932 Yrs. **Director** Usual Residence of Decedent 28a-f show 10b. County within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location **Linthicum** iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Anne Arundel MD 1 Tes 2XXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 308 Chestnut Rd. 21090 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes XX No Specify. White "natural", 3 ₩ Widowed 4 □ Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Page 1 and 2 should be filed within 7: ment of Health and Mental Hygiene. sant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)
Emma Updegraff Joseph Leo Albright, Sr. 19a. Informant's Name/Relationship (Type, Print)
Karen L. Frush / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 308 Chestnut Rd., Linthicum, MD 21090 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Cedar Hill Cemetery 06/29/2012 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Eureral Service Balley Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 M01452 Wee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ORSTRUCTIVE LUNG DISCOSE Immediate Cause (Final Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month Day Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 1 Yes 2 No 1 Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, s after death. filled in by the funeral 27. Manner of ath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred tural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar Tonth, Day, Year)

who completed cause of death (Item 23a) (Type, Print)
- RAZ MID 578

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 06mth David Louis Brown Sr. 2<sup>Pay</sup> 2 der 2 0245A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis N/A Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours (Month. Day, Year) 219-80-2415 1 M 2 □ F Director 51 08/27/1960 Maryland Usual Residence of Decedent i Hygiana. other than "neturel", or iteme 23e or 28e-f show vent, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location filad within 72 hours after daath with tha Maryland 10d. Inside City Limits Director MID Baltimore Co. Randallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4730 Atrium Ct. 21117 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Completed by 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 Z Ln Grade (0-12) College (1-4 or 5+) Laborer Unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) parmit. Paga 1 and 2 should ba fila Dapartmant of Health and Mental I importent: If item 27 ie marked of eny injury or other treumetic eves page. and Mental F ည Unk Pearlene Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alease Armstrong(Sister) 557 E. 38th St., Baltimore, MD 21218 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State on-site Crematory ☐ Donation 5 ☐ Other (Specify) Baltimore, MD ignature of Funeral Service Livense Jasepha Affres Frown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD21217 But 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and defached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death cartificate be axecuted within 24 hours after death.

To the Funeral Director: Atter this certificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be deteched for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Disease fcate has baan sign, page 2 should b 1 Yes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient မ 1 Yes 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 6/23/12 mard Mille D47683 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Raymond Miller

31. Date filed (Month, Day, Year)

**JUN 28** 

1525

DWING

3. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Brown Physician/ 10:30 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** Maryland Madical of Baltimore N/AIf Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Director 1 🗆 M 2 🙀 F 61 01/27/1951 Maryland 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits at 10a. State with the Maryland Director notified MD N/A Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be n Funeral 556 S. Bentalou St. 21217 U.S.A. "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items amy injury or other traumatic event, the Medical Examiner muone. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗽No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Home Health Care unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Brown Eleanora Oden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jermaine Wilson(son) 2562 Arunah Ave., Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place)
On-site Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 7-3-12 Baltimore, MD Donation 5 Other (Specify) of Funeral Service Livensee <sup>2</sup>ਹਿਤਵਾਈ ਅਜ਼ਿੰ•ਇੰਸਲਿਆ Jr. 2140 N. Fulton Ave., Funeral Home, Baltimore, I Signatur PA MD 21217 2 . art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or yeart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a cons Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No ò Pregnant at time of death ed by the a detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy perform 1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director; /
completely filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29c. License number 8 100 568 m cause of death (Item 23a) (Type, Print) 30. Name and address of person whe Patrick Benna, Baltimore, MD

DHMH 17 Rev 06-2011

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10:45<sup>p</sup> Physician/ Month 2012 BRIGGS KATRINA 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death ROCKVILLEExaminer MONTGOMERY CASEY HOUSE 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In vrs. last birthday) Funeral Days 8/20/1985 577-17-7338 VASHTNGTON, DO Director 1 AM 2 D F 26 Yrs. and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No WASHINGTON DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
UNITED STATES Funeral 20001 540 COLUMBIA RD NW 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc δ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifyBLACK 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE SALES WOMAN 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ WILLIE LEE CLARK ROSA RIGGS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shi Department of Health ar Important: If Item 27 is any injury or other trau 640 PARK RD NW #13 WASHINGTON, DC 20010 JANNIFER CLARK/AUNT Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Dopnation 5 Other (Specify) cemetery, crematory or other place) HERITAGE CEMETERY 6/29/2012 WALDORF, 21. Signature of Funeral Service License 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE NE WASH., DC 20002 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Priysician/ aACQUIRED disease or condition resulting in death) IMMUNE DEFICIENCY SYNDROME Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, hading to immediate cause. Enter Underlying Cause (Disease or injury Due to jor as a consequence of sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Month Dav Pregnant at time of death ed by the a detached f q | Linknown 9 Unknown s been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ※ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 X No 2 XNo 1 Tes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Hospice 1 ☐ Yes 2√ No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1, Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation
6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 6/22/2012 D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

32 Registrar's Signature

6001 MUNCASTER MILL RD.

JOSEPH

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ROCKVILLE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Пау Physician/ Month Year Betty Louise Buffington 2012 June Medical 8 9:05A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 8. Date of Birth
(Month, Day, Year)
Jan. 25,1941 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) 1 Year **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Director Yrs 173-32-7015 Marvland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4493 Bark Hill Rd. 21791 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify Completed White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 10 owner/operator/business mgr. custom stitchery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles Frederick Eyler Helen Mackley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry E. Buffington Jr./husband 4493 Bark Hill Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6/21/2012 | nr. Union Bridge, MD 4 Donation 5 Other (Specify) Mt. Union Cemetery 21. Signatur of Furneral Service License 22. Name and Address of Facility Hartzler Funeral Home, P.A. 0 attarine Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a onsequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last signed by the attending physician d be detached for use as the burial on cer Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month 5 Other (specify) Pregnant at time of death Month Day Year Unknown g 🗌 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed within 24 hours after death.

To the Funeral Director: After this certificate 2 40 Yes 2 1 Yes 25. Was case referred to mediçal Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 406 ပ္ Inpatient ☐ ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Peath Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifier 29a. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated -0054218 address of person who completed cause of death (Item 23a) (Type, 11 Man B. Kanena, 349 Maleoly dive West minster MD 21157

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2 Day Physician/ Year Month ALLEN BECKER 00 a Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltmore Boldinge N/A Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Director 181-20-8566 1X M 2 D F 85 04/24/1927 PA in than "natural", or items 23a or 28a-f show the Medical Evantiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 21 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 POMONA EAST, #311 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 □ XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) INVESTMENT REAL ESTATE permit. Page 1 and 2 should be filed w Department of Health end Mentel Hyg Important: If Item 27 Is marked othe eny Injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BECKER YETTA FREIDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FLORA BECKER/WIFE POMONA EAST, #311, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS CEM: 06/27/2012 OWINGS MILLS, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ espirator disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner vigestige Heart Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the attending physician and ched for use es the burial-transif or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy To the Hospitel or Attending Physician: The law requires that the death within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for I in the past 12 months? Month Day 5 Other (specify) g 🗌 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Amal Fibrilla non. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Spec Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 25, 2012 H001437 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai Hospital of Bulhmore, 2401 W Suzette Johnson Currell 31. Date filed (Month, Day, Year) 32. Registrars Signature State 28 2012 Registrar

DHMH 17 Rev 06-2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 20565 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Hassel Wayne Coe June 27, 2012 12:55 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1253 Armistead Way Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) Months Hours 225-44-6577 **XX** M 2 □ F Director Oct 7, 1936 VA Usual Residence of Decede 28a-f shov 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits with the Maryland Director notified MD N/A 1XX Yes 2 □ No Baltimore 10e. Street and Number ō 10f. Zip Code 109. Citizen of What Country? ms 23a or must be r Funeral 1253 Annistead Way 21205 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, ite Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 1 Never Married 2XX Married ģ 1XX Yes 2 L If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: U.S.A. Completed 3 Widowed 4 Divorced 58-80 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Govt. (Army) Chief Warrant Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hassel Scott Coe Mattie Mae Garland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Ruth Coe (Wife) 1253 Armistead Way Balto, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) cemetery, crematory or other place) Crestlawn Memorial 7/2/12 Marriottsville, MD 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto, MD 21211 23a. Part 1. Enter the disease, or combligations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Unknown Onset and Death OF Physician/ Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 Yes To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ate has b autopsy After this certificate 2 No 1 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 24 hours after death Funeral Director: / Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F the only one) 29b. Signature and title of certifie

Registrar

31. Date filed (Month, Day, Year)

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29d. Date signed (Month, Day, Year)

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awi, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 23 Physician/ 2012 JUNE Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death WASHINGTON MEDICAL ANNE BALTIMORE (OLEN BURNIE HRUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 215-52-3189 Months Director 1 🗆 M 2 🔀 F 68 01/11/1944 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 nours and acceptance of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Important: If item 27 is marked other than "natural", or items 29a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8096 Montague Ct. 21086 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 🙀 Married ð 1 ☐ Yes 2 🛣No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Nurse Mercy Medical Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emanuel Witherspoon Sylvia Lester 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Brown (Daughter) 7010 Neuhoff Lane, Charolette, NC 28269 20b. Place of Disposition (Name of cernetery, crematory or other place)

Mt. Zion Cemetery 06/29/12 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal fr 4 Donation 5 Other (Specify) Mt. Baltimore, MD Signature of Funeral Service Licer 2) Usephdon Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List gally one cause on each line. Approximate Interval Between Contraintactional bloo Physician/ disease or condition resulting in death) .uook Medical Due to (or as a consequence of) Examiner cumb Sequentially list conditions. Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury Due to (or as a cons luence of burial-transit or Attending Physician: The law requires that the death certificate be executed early deep and that initiated events resulting in death) Last attending physician Physician/Medical Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ♣ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month the 9 Unknown P.O. is certificate has been signed by t director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 No ☐ Yes 2 No B 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ျပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 🔲 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital 24 hours a Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier Chilamo ) of Charpers MD D0085±14 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUILLERHO JOSE GIANGRECO 301 HOSPITAL DRIVE, GLENBURNIE, MD 20161 Date filed (Month, Day, Year) State JUN 28 2012

Registrar

CRAWTORD, BETTY

State Registrar KENNETH

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

115 EAST

INDY BERG MD

32. Registrar's Signature

Deneur B

MELVOSE AVE BALTIMORE 21212

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryand, Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 26,2012 2025 Steven Durbeck Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 8. Date of Birth (Month, Day, Yea 1950 5 Social Security Number Age (In yrs. last birthday) . Birthplace (State or Foreign Country) **Funeral** 60 **Director** 264-86-6108 1**X** M 2 □ F April 29. <del>1951</del> -Massachusetts Usual Residence of Deced or 28a-f show at 10c. City, Town or Location 10d. Inside City Limits Director or items 23a or 28a-f siminer must be notified Maryland 1 🗆 Yes 2 👿 No Anne Arundel Churchton 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1203 Gwynne Avenue 20733 USA 12. Was Decedent Ever in U.S.
Armed Forces?

1 X Yes 2 No 1968—
If Yes, Give 1072 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify item 27 is marked other than "natural", other traumatic event, the Medical Exar white 3 Widowed 4 Divorced 1972 Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Sales Verizon Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H ည Windsor D. Durbeck Patricia A. Stevenson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Edythe Buehring/sister 1440 Somerset Court Mundelein Illinois 60060 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important; If it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory,Inc. | 06/27/2012 | Baltimore,Maryland 4 ☐ Donation 5 ☐ Other (Specify) Custer 22. Name and Address of Facility Cremation Society of Maryland, Inc. 21. Signature of Fulleral Service License Stephanie 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospita 1 Yes 2 No Other: မ Natient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 10 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signatu 29c. License numbe 29d. Date signed (Month, Day, Year,

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Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dlubala С. 2012 3:10 Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 2 Cedar Circle Pasadena Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours (Month, Day, Year) 218-28-2607 Director 1 🗌 M 2 🗷 F 81 Nov. 1930 West Virginia 23, Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel <u>Pasadena</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2 Cedar Circle 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) N/A <u>Machine Operator</u> Book Binding Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Waglie (Sister) 3rd Street Baltimore. <u>Marvland 21225</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 06/29/2012 Brooklyn Park, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena. Marvland 21122 MOO-732 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Phystcian: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ₹ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🗷 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 1 Yes 2 🕅 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending 2 No ☐ Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the heat of my knowledge 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D-40521 Jime 26,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 HOSPITAL ARIVE SUITE 208 MEN BURNIE, MD 21061

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Registrar

State

DR OCHANES 31. Date filed (Month, Day, Year)

barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 11:45p M Donatelli Joann JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTE TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours **Director** 216-34-3995 1 □ M 2 X F 76 Oct. 2, 1935 Maryland Usual Residence of Decedent or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 X Yes 2 No Ocean City Maryland Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21842 8802 East Biscayne Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕅 No 1 Never Married 2 X Married Completed by 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene.

is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Eurich J0sephinr DiPino William permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. John or other traumatic 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218428802 East Biscayne Drive Ocean City, Maryland Daniel T. Donatelli, Jr, Baltimore, 20a. Method of Disposition

1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of Strengton) Schronech 20c. Location - City or Town, State Date 6-29-2012 ☐ Donation 5 ☐ Other (Specify) Fullerton Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. onature f Tune a Service Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed Encephalo path 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural  $5 \square$  Pending 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License numbe 2120 State Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Engeler. Month **Physician** 2 race June 21, 2:55 PM M 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5550 Tuckerman Lane #536 North Bethesda Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💢 F 85 Director 102-20-1432 Sept 30, 1926 Florida Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural;", or items 23a or 28a-f show 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at MD Completed by Funeral Director Montgomery 1 ☐ Yes 2 ☐ No North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5550 Tuckerman Lane #536 20852 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. or other traumatic event, the Medical Examiner 1 X Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 banking financial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Paul Engeler ၉ Charlotte Elizabeth Wendel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health a
Important: if item 27 is
any injury or other trau
once, Louise Lees/sister 9701 Elrod Road Kensington, MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Refrimore. MD 21201 21. Sign dure of Funeral Service Ronald 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and the burial-tran Due to (or as a consequence of) physician

**Physician** /Medical Examiner

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Cical		a failure to	10.0, ve.			
y sicial livie	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		pic pregnancy ar (specify)		23d. Date of delivery Month Day Year	
ted by FI	Part II. Other significant conditions of	23e. Did tobacco 1 ☐ Yes	use contribute to the cause of death?  No 3 Probably 4 Unknown			
Pidillo		24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No				
2	25. Was case referred to medical examiner?	Hospital:	0.11	h (Check only one)		
2		Hospital: 1   Inpatient 2   ER/Outpatient 3	me 5 Residence			
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		28d. Describe how inju	ury occurred		
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
S Inch	29a. Certifier 15 Certifying Ph (Check only one) 2 Medical Exam	and due to the cause(stred at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)			
YIN!	29b. Signature and title of certifier	eds	29c. License number 5 3 6 9 )		ate signed (Month, Day, Year)  TUNE: 21: 2012	
	30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	+110, Ro	chille, mo		

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

28 2012

within 24 hours after death To the Funeral Director;

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>012</u> Physician/ Henry Elliott 13 June 4:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Manor Care of Roland Park Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes Mar 16, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min. 86 Director 415-30-9100 Tennessee Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at rector 1 🖫 Yes 2 🗌 No MD Baltimore ā 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral 4660 Falls Road @1209 USA death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or þ 1 Never Married 2 Married 2 No within 72 hours after more, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Divorced 4 Divorced b1ack Completed Medical 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) the unk unk Bethlehem Steel Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Rosalind Pitts/Goddaughter Truxton Court Edgewood, MD 21040 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) i,n state 21. Sign turn of Funeral Service Licensee 22. Name and Address of Facility State Anato Baltimore. Director Anatomy Board 655 W. Baltimore Street more, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or lingury that initiated events Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☐ Yes 2 ☑ No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. 2 Accident Investigation 6 Could not be Suicide 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the control of my homeoge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2

To the F 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2 29c. License number 6/15/12 D0069314 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8813 Waltham Woods Rd Parkville Mo Prajagati

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

28

. Registrar's Sign a re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 06 25 Day Physician/ 2012 8:42P thnie Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** N/A 223 S. Franklintown Ct. Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday, 8. Date of Birth **Funeral** Months Hours N. Carolina 0 972 17 133 240-48-9935 78 Director Usual Residence of Decedent show 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland notified at Director 28a-f Baltimore ¥□ Yes 2 □ No N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 21223 U.S.A. 223 S. Franklintown Ct. er than "natural", or items the Medical Examiner mu death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? þ 1 K Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. fant: If item 27 is marked other than "natural", or ury or other traumatic event, the Medical Examirury or other traumatic event, the Medical Examirury or other traumatic event, the Medical Examirury or other traumatic event, the Medical Examirum or other traumatic event or other event or ot Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Black Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 11th Grade College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Lula Barnett Joseph Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 223 S. Franklintown Ct., Baltimore, MD 21223 Tammy Edwards (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H
Important: If ite
any injury or oth 1 Removal from State Zion Cemetery 06/30/12 Baltimore, MD Mt. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licen Fore Thomas of Brown Jr. Funeral Home PA MD 21217 2140 N. Fulton Ave., Baltimore, in Approximate Interval Between Onset and Death Physician/ 1Pal Medical resulting in death) Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury physician and sthe burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE attending 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? signed by the atte Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 Pending iniury 1 Natural Accident after death. Investigation by the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled in t within 24 hours a

To the Funeral D

completed filled i Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 6 m

State Registrar 31. Date filed (Month, Day,

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30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Shores

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1302 Mary M. Farrell 14/2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Union Memorial Hospital Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 217-60-3296 Director 1 □ M 2 🖫 F 59 1952 Nov 8. Kentucky show 10d. Inside City Limits f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Baltimore <u>Maryland</u> N/A10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 21211 **USA** 2902 Miles Avenue death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 🏋 ☐ No Specify. 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Laverne Potter Harmon Underwood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Maryland 21211 Michael S. Farrell, Husband 2902 Miles Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Department of Himportant: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. 06/27/12 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conse of nce of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Year 5 Other (specify) Pregnant at time of death signed by the at d be detached for a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed?

1 Yes 2 No death? 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🗶 No ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide determined 24 hours Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number line 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registr 's Signa

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Farrell June 12:50 pM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 14224 Oxford Drive Laurel Prince George 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 170-44-4327 1 □ M 2X XF 93 Sept.10,1918 PΑ Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State the Maryland Director MD Prince George Laurel 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9 ms 23a or must be r Completed by Funeral with U<u>SA</u> 14224 Oxford Drive 20707-5853 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Forces 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white 3XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Preparation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Dugan Stella Przybylowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Farrell Oliver/Daughter 14224 Oxford Dr., Laurel, MD 20707-5853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Hanover TWP., June Date 30. 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State St.Mary's Cemetery 4 Donation 5 Other (Specify) 2012 Pennsylvania 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01053 313 Talbott Ave., Laurel MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final piration Physician/ disease or condition resulting in death) neumonia Medical o (or as a consequence of) Examiner eurologica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury Hospital or Attending Physician; The law requires that the death certificate be executed 10 attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has be director, page 2 s autopsy performed? Yes 2 No death?
1 ☐ Yes 2 ☒️ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{X}\) Residence 6 \(\sum \) Other (Specify) 2 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆

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31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signature

29c. License number

M. Harrison MD 6095 Manshalee Dr. Elkridge MD2

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29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Raymond Feeser 7:10a June 2012 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore **Examiner** 300 Maple Avenue Essex Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 213-07-8698 1 X M 2 🗆 F 93 Months Days Hours Min OCL 9 <sup>Y</sup>2918 Director PA Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director MD Baltimore Essex 1 Yes 2 No 10f. Zip Code 21221 ō 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a o Examiner must be 300 Maple Avenue Funeral USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. rmed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: "natural", Specify: White Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. Seagrams Co. Machinist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H permit. Page 1 and 2 should be fill Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve မှ George T. Feeser Lydia M. Leightner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Feeser /wife 300 Maple Avenue Balto. MD 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 6/30/12 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final Izheimer Physician Dementia disease or condition year Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions cause. Enter Underlying Cause (Disease or linjury Dire to (or as a consequence of and I-transit Exami Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death 2 No ed by the a g Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown has been sig ge 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate ha 1 🗆 Yes 2 XNo 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one. Hospital 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home this ( 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending Natural iniury work?
1 Yes 2 No 5 Pending thin 24 hours after death.

the Funeral Director: After mpleted filled in by the fun Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

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complete only one) 29b. Signaturé a D0032548 Lee Colvin, MD, Bayview Medical Center Baltimore revr

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State Registrar 31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:00 P June 2012 Fields Ruby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA Baltimore 1617 Bentalou Street If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1 □ M 2 🖺 F 98 215-22-0978 Director 01-02-14 VΆ Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Examiner must be notified at with the Maryland **Funeral Director** XX Yes 2 No Baltimore MD NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 23a USA 21216 1617 N. Bentalou Street permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muonee. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes XX No Black, White, et African þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes XX No Specify: Specify: American 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Social Security Admin. Cafeteria 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Verline Jackson Henry Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5475 Cedonia Avenue Baltimore, Maryland 21206 Patricia A. Jackson-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other Arbutus Mem. Pk. 06-29-12 Arbutus, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 . Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ IN RATETION Acure MYOCATI disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Myperection TIE702 Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Fctopic pregnancy in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury Natural 5 Pending Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 3040 dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a BWI mossmin mik Huchon 200 32. Registrar's Signature Date filed (Month, Day, Year) State

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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Patricia Physician/ Month Hollingsworth 7:19 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore N/A University of Maryland Medical Center If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Rirth Birthplace (State or Foreign Country) Funeral (Month, Day, Year) 579-56-9464 Director 1 □ M 2**X** F 71 Feb 4, 1941 Maryland 28a-f show 10a State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland must be notified at 10d. Inside City Limits 1 Yes 2X No Maryland Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? or items 23a 700 Castlewood Drive 20774 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3

Widowed 4 □ Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Cab Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Zack Clark Allen Hattie Elizabeth Bassett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Theresa Brewer, Sister 605 Highway 13 North Collinwood, TN 38450 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/26/12 Baltimore, Maryland 21. Signature of Funeral Service Liegnsee Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, Inc. Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ Due to (or as a consequence of): disease or condition Medical resulting in death) **Examiner** year Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examil > 2 years law requires that the death certificate be executed Cause (Disease or injury that initiated events potit Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No the 9 Unknown g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ailure Polmonary edeme 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an (arconona autopsy performed? Yes 2 No certificate has page Hospital or Attending Physician: The 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospita 1 Tes 2 X No ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral c 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? (Month, Day, Year) 1 X Natural 5 Pending e Funeral Director: Aft Director: Aft 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0 102528 June 25 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 60 Baltimore, MD 21201 M.D (greene

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

JUN 28 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 Month June Harrison - Webster 20182 8:54 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death I medical (e Baltimore University of Morylor Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign **Director** 82 250-46-9724 1 M 2 K F 04/29/1930 South Carolina Usual Residence of Deced 28a-f shov 10a. State 10h. Counts 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified MD Glenwood Howard 1 Yes 2 No 10e. Street and Numbe ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 3316 Shady Lane 21740 U.S.A. ural", or items ! 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🍱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: Black 1 Yes 2 No Specify. "natural" Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Special Education Coordinator Education alth and Mental Hygie 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Robert Partlow Zorado Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Addison Webster / Husband 3316 Shady Lane, Glenwood, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 Donation 5 Other (Specify) 06/27/2012 Anatany Gifts Registry Hanover, Maryland 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Poset and Death Interval Between Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) statis months Medical Examiner olex nare Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury Examiner e to (or as a consequence of burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical P.O. Box 68760 the attending phone IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death Vear 1 ☐ Yes 2 ₪ 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performe Hospital or Attending Physician: The this certificate 1 Yes 2 No Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 - No 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: hin 24 hours after death. the Funeral Director: After Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 No Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 2

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of p

Street

pleted cause of death (Item 23a) (Type, Print)

32. Registrar Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20580 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death JUNE 26 Day 2012 Physician/ 12:15 P<sup>M</sup> HUMPHRIES KATHERINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Maryland Masonic Home Cockeysville 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours (Month, Day, Year) une 1, 1920 Maryland 1 🗆 M 2 💢 F Director June 213-18-7882 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Director 1 ☐ Yes 2 🕅 No Cockeysville <u>Maryland</u> Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe Funeral 21030 USA 300 International Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11, Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Trockenbrot Florence Zieget, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 324 Sandy Knoll Dr., Douglestown, PA Heather Humphries Law/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Bongtion 5 ☐ Other (Specify) Loudon Park Cemetery 7/03/2012 Baltimore, Maryland mature on sure Suit Lion 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clary used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ns that ca 23a. Part 1. Enter the disease, or complicati shock, or heart failure. List only one ca Interval Between Immediate Cause (Final disease or contion Onset and Death Vosculon Phoician/ selvo eus Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last and -trans Exar Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be e 24 hours after death. Funeral Director: After this certificate has been signed by the attending physicia Box 68760 IF FEMALE: Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Fctonic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) ed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed lipage 2 should be det Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Course 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?
1 \( \sum \) Yes 2 \( \overline{\ove Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death. To the Funeral Director. A: completed filled in by the fu Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🔲 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 6126112

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3508 B

LIBERT

12-04567 Barbara Hairston

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 20581

		1- For State Certificate of Death Registrar		Reg	g. No.	
Physicia	n/	Decedent's Name (First, Middle,Last)	-	2. Date of Death Month	Day Year	3. Time of Death 0558 hrs
Medical Examin		Barbara Ann Hairston  4a. Facility Name (if not institution, give street and number)  4b. City, Town, C	or Location of De	June 17, 20	4c. County of Death	
	ľ	Sinai Hospital  Baltimore			n/a	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye			n(MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director		215-56-5482 1 M 2 X F 64 Yrs. Months Da	ays Hours	Min. Nov 30	, 1947 Co	untry)Maryland
Any	- h-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
						1 X Yes 2 No
faryland	뢍	Maryland n/a Baltimore  10e. Street and Number 10f. Zip Code		. 10	g. Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho ootified at oece		4800 Seton Drive 212	215		USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  not: If item 27 is marked other than "natural", or items 23s or 28s-fahe or other traumatic event, the Medical Examiner must be cotified at noce	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of H			14. Race - Amer White, etc.	ican Indian, Black,
death or ite		Never Married 2 Married 1 Yes 2 X No		,	Specify: R	
s after	<u>a</u>	3 X Widowed 4 Divorced 11 Yes, Give Year 1 Yes 2 X No 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occup		d of work done	16b. Kind of Business/	lack Industry
5-0036 led within 72 hours al Hygiene. other thao "natural the Medical Examio	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)				
036 thin 7 thas	톍	12 n/a Housekeeper	<u> </u>		Housekee	ping
5-0 led wi Hygie I other		17. Father's Name (First, Middle, Last)	18.Mother's N	lame (First, Middle, M		
21215-0036 Jud be filed within 7 I Mental Hygiene. marked other than marked other than cevent, the Medica	8	Wilbur John Thomas  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Str	Cora	a Allin		
nore, MD 2121; ggs. 1 and 2 should be fil rt of Health and Mental 1 t: If item 27 is marked other fraumatic event,	욘	Kena Nicole Norris/Niece 3927 Chester				
ore, MC es 1 and 2 s of Health a If item 27	1	20a. Method of Disposition 20b. Place of Disposition (Name of c	cemetery,	Date	20c. Location - City or	Town, State
nor		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Departure 5 Other Specify: Dulaney Valley M	emorial	06/23/2012 Gardens	Timonium	, Maryland
Baltimore, permit. Pages 1 as Department of He Important: If ite	- 1	21. sign = for year Service License 22. Name and Addre	ess of Facility	Home of Du	laney Vall	ev Inc.
E E G B M	_	Bryan W. Clary 10 W. Pac 23a. Part I. Enter "e lisease, or complications that caused the death. Do not enter the mode of dyin	donia Ro	oad, Timon	ium, Maryl	and 21093 Approximate Interval
Physician Medical		failure. List only one cause on each line.				Between Onset and Death
Examiner	1	Immediate Cause Final disease or condition resulting in death)  a. Hypertensive Atheroscleroti  Due to (or as a consequence of):	c Cardi	ovascular	Disease	<del>                                     </del>
		Sequentially list conditions, b				
	ije	if any, leading to immediate Due to (or as a consequence of):				
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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68760, certificate be nding physicilse as the buri			3 Ectopic pr	regnancy	Month	Day Year
Box 687  te death certific  the attending p  ted for use as the	Physician/	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 ✓ No 9 Unknown  9 Unknown				
Aecords, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for u			e given in Part I		bacco use contribute to	
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rds, requirements been should	ete			24a. Was autop	sy prior to	utopsy findings available completion of cause of
eco he law ate has	Completed			perfor 1 ✓ Yes	rmed? death? 2 No 1 ✓ \	'es 2 No
al R	Be C	25. Was case referred to medical	ace of Death (CI			
Division of Vital Records, P.O. tal or Atteoding Physiciao: The law requires that the raster death.  al Director: After this certificate has been signed by led in by the fameral director, page 2 should be detach	일	1 ✓ Yes 2 No Impatient 2 ✓ Ervoutpatient 3 Don	Other <sub>4</sub> N		Residence 6 Other	er:
ding F		27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Ir	Yes 2 N		iow injury coodings	
SiO Afteo r death ector: by the	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office	e building, etc.			Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)		or Town, S	state)	
Hospi 24 hou Fuocr			, date and place	e, and due to the caus	se(s) and manner as sta	ated the cause(s)
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.	ense number	nou at the time, talle	29d. Date signed (M	
	Σ		C.M.E.		June 18, 2012	, ==,,=,,
		30. Name and address of person who completed cause of death (Item 23a)			<u> </u>	
Y		Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltim	ore Street, i	Baltimore, MD 2	1223	
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	·			
Regist	rar	JUN 2 8 2012 Janua B. Sales				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year Month **Physician** Maraaro 45 AM JUNE 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Manor Care Ruxton Towson 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5 Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) **Funeral** Year) Months Days Hours Min 1 □ M 2X F 219-40-0476 69 Director Nov. Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ans. If item 27 is marked other than "natural", or items 23a or 28a-f show ans. If item 27 is marked other than "natural", or hitems 23a or 28a-f show ans. If when traumatic event, Pre Medical Expringer must be notified at 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location 1 □Yes 2X No Director MD Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Silver Fox Court 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No white Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Stock Broker Chapin Davis 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Arthur van Reuth Margaret Opitz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) husband James P. Hill, Jr. 2 Silver Fox Court; Cockeysville, MD 21030 20a. Method of Disposition
1 ☐ Burial 2/20 Cremation 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State Department or Important: If any Injury or once. Hilltop Service Corp. 6/26/2012 4 Donation ☐ Other (Specify) Towson, MD 22. Name and Address of Facility 21. Signature of 1050 York Road Inc. Towson, MD 21204 Ruck Towson Funeral Home, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** -IVEV one day disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy for in the past 12 months? Month Year 5 Other (specify) ned by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Physician: The performed 2 No 1 ☐ Yes 2 No 1 ☐ Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Hospital or Attending 1 Natural 2 Accident (Month, Day, Year) Injury 5 Pending 1 TYes within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ∏No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar 29b. Signature and fittle of certifie

31. Date filed (Month; Day, Year)

sis of

Name and addre

DHMH 17 Rev 1/2001

cause of death (Item 23a) (Type, Print)

Ado

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Sandra Herman 2012 20583 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day June 18, 2012 0900 hrs **Medical Examiner** SANDRA HERMAN 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Anne Arundel 2608 Midway Branch Odenton If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Days Months Hours Director 01/13/1956 56 PA178-46-1531 1 M 2 XF Yrs Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b County 10c. City. Town or Location any. s 23a or 28a-f show e notified at once. Yes 2 X No ANNE ARUNDEL ODENTON within 72 hours after death with the Maryland rector 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ä 2608 MIDWAY BRANCH DRIVE #101 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, event, the Medical Examiner must be "natural", or items Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 XNever Married Yes 2 X No. If Yes, Give Year Yes 2 X No specify: Specify: WHITE Widowed Δ Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036 Pages I and 2 should be filed within 7. ent of Health and Mental Hygiene. 5+ VETERINARIAN MEDICAL t: If item 27 is marked other other traumatic event, the Me 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BEN HERMAN ANN MELNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD HERMAN/BROTHER 67 BELLMORE DRIVE, PITTSFIELD, MA 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) Burial 2 X Cremation 3 Removal from State ment ( CARROLL CREMATION 06/27/2012 HAMPSTEAD, MD Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MDApproximate Interval **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and failure. List only one cause on each line /Medical Death a Pentobarbital Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and ian/Medical UNPENDED AMENDED attending physician or use as the burial The law requires that the death certificate be Box 68760, IF FEMALE 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months Pregnant at time of death Physicia 5 Yes 2 No 9 V Unknown be detached for Unknown the 23e. Did tobacco use contribute to the cause of death? <u>о</u>. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 V No 3 Probably 4 Completed Records, page 2 should 24a. Was an 24b. Were autopsy findings available certificate has been autopsy prior to completion of cause of performed? death? Yes 2 V No Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medica 26.Place of Death (Check only one) of Vital Be Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other: Scene After this ဥ 1 V Yes 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27 Manner of Death Certification: Infused veterniary euthanasia medication FOUND 1 Natural Yes 2 V No death. Pending the Jun 18, 2012 0855 hrs 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 3 🗸 Could not be Suicide or Town, State) 2608 Midway Branch, Odenton, MD determined (Specify) Single Family Home 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 54 Medical within 2 To the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) June 19, 2012 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 20584 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ne Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death tomaro Johns N/A 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yks. last birthday **Funeral** 9. Birthplace (State or Foreign Country) Director 206-42-5693 1 🛛 M 2 □ F 60 11/20/1951 Usual Residence of Deceden PAshow ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/ABALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral FALLSTAFF ROAD, #207A 21209 USA items 72 hours after death filed within 72 hours after death al Hygiene. d other than "natural", or item: went, the Medical Examiner m Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify. WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 5+ COMPUTER SCIENTIST DEPARTMENT OF DEFENSE other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental Fis marked or မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic traumatic ALFRED HIRSCH ANNE LASSIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY HIRSCH/WIFE #207A, 3011 FALLSTAFF ROAD, BALTIMORE, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CHEVRA AHAVAS CHESED 06/26/2012 RANDALLSTOWN, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph\_sician/ Acute Myeloid leukemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial physiciar Physician/Medical Box 68760 the as nding IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Year Month Day Pregnant at time of death 2 No the. Unknown 9 Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 2 No 3 Probably 4 Unknown should 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2 No 2 🗆 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 2 No Other: 1 Yes Certificate: To 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director, A Accident Investigation Suicide 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check

completely State Registrar

DHMH 17 Rev 06-2011

29b. Signature and title of certifier

Jocelyn

31. Date filed (Month, Day, Year)

28 2012

ynowozney

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Worney

MU

32. Registrar's Signature

MD

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

2012

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Ramon TravaNTE 12-04344 INGram **UNK UNK** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 20585 1- For State Certificate of Death Rea. No Registrar 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day Year June 8, 2012 6/9/2012 0305 hrs Medical Examine Ramon Travante Ingram 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Interstate 495 on the Woodrow Wilson Bridge Oxon Hill If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Director Country) 1 X M 2 F 29 07/04/1982 MD 212-11-3579 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits iny 10a State 10b County Ft. Washington 1 X Yes 2 No MD Prince Georges . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a or 23a-f sho or other traumatic event, the Medical Examiner must be notified at once. rector 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number **MZA** 20744 靣 7908 Prentice Ct. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. White etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Specify: Black 3 Widowed ≥ 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) **Baltimore, MD 21215-0036** Private Landscaper 7.2 Ъ. 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara P. Philpot Dannie R. Ingram 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7908 Prentice Ct., Ft. Washington, MD 20744 Clara Ingram / mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 07\55\5075 Suitland, MD Cedar Hill Cemetery Denation 5 Other 21. Signature of Funeral Service 22. Name and Address of Facility Strickland Funeral Services Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Las and Physician/Medical 🗵 AMENDED #2perME,G928,6/28/2012,WS UNPENDED ficate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year 1 Live birth 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? 2 No Yes 2 No 1 Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes 2 No 28a. Date of Injury (Month Day,Year) Jun 9, 2012 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification Driver auto auto collision 1 Natural 0255 hrs 1 Yes 2 ✔ No neral Director: 5 Pending within 24 hours after death. 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 Could not be or Town, State) -495 on Woodrow Wilson Bridge, Oxon Hill, MD determined To the Funeral I 4 Homicide (Specify) Interstate/Express 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the vasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) June 10, 2012 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) OCME Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

JUN 28 201

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #17 Per FH G933 11/16/2012 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ INMAN 0<sup>Menth</sup> DORI 20 2 0°1°2 10:20p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Villa Nursing Home Catonsville Baltimore, Co. 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth **Funeral** 1 □ M 2 🔀 F 0670571923 117-16-3099 89 Virginia Director Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director B/A 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ms 23a or must be n Funeral 1112 Cherry Hill Rd. #H 21225 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Medical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 🖈 ☐ No Specify. "natural", Specify: Black Completed 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 l and Mental Hygiene. 7 is marked other than "r 12th Grade College (1-4 or 5+) the Uniform Company Seamstress event. Be 17. Father's Name (First, Middle, Last) William Dallas Weston 18. Mother's Name (First, Middle, Maiden Surname) 2 Dallas Westin Annie Gatling permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1112 Cherry Hill Rd., Brooklyn Park, MD21225 Sheraton Woods(grandson) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 6-22-/2Baltimore, MD on-site Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 2分份的 The Borwn Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, M 21217 MDa. But 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line.

mediate Cause (Final Approximate Interval Between Onset and Death Physician) Ischemic isease or condition Medical resulting in death) **Examiner** Cardiovascular Diffese thenschoolie squeritally liet our differie, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events that the death certificate be executed and -tran Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Pregnant at time of death 1 Yes 2 9 Unknown Linknown detached signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown cate has been sig page 2 should b Dementia 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? certificate 1 Yes 2 No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other မ 1 Inpatient 2 ER/Outpatient 3 DOA ★ursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month) Day, Year) WSITIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

KODOLPO F

31. Date filed (Month, Day, Year)

FR NAN 2St

516 N. Rolly Rd Str 205 Catonsn'16, MD 212 28

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Physicia Medical Exami						Ι,	2. Date of Dear	Day	Year		3. Time of 1743	
		4a. Facility Name (if not institution, give street and number)	4	b. City, Town, or L	ocation of	Death	June 24, 2		. County of	Death		
		1231 Poplar Avenue		Halethorpe				В	altimore	Cou	nty	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	)	If Under 1 Year	If Under	-	8. Date of Bir		1			tate or
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<b>≥</b> 5 ± 5 ≥		Robert H. Jones / Father 560  20a. Method of Disposition 20b. Place of Disp	9 ]	Edmondson	n Ave		, Balti Date	more	e, Ma	ryl	and 2	21229
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of Vital Records, P.O. Box 68766 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phytimeral director, page 2 should be detached for use as the b		Part ii. Other significant conditions contributing to death but not resulting in the	e una	derlying cause give	en in Part I		23e. Did tob	acco u	se contribu	te to th	e cause o	of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter cleath.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	d b						1 Yes	2	No 3	Proba	oly 4 🗸	Unknown
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Divi	Certification:	3 X Suicide 6 Could not be determined (Specify) found at		•	aing, etc.		or Town, Sta	ate) 12	31 Pc	pla	r Av	e.
Hospi 24 hou Funer tely fil		29a. Certifying Physician: To the best of my knowledge, death occ (Check only			and place.		alethor			stated		
Division of Vital Records, P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investig	gation	n, in my opinion, d	eath occur	red at th	ne time, date a	nd plac	e, and due	to the	ause(s)	
FSF5	ž	29b. Signature and title of certifier		29c. License n	number			29d. Da	ate signed	(Month	, Day,Ye	ar)
		Pote an - toller ~		O.C.M.	E.			June	26, 201	2		
0	Ì	30. Name and address of person who completed cause of death (Item 23a)		00 \A/ D. !!!	0:	4.5.	·	0422				
	10	Patricia Aronica-Pollak MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year) 32. Registrar's Signature	90	00 W. Baltimo	re Stree	t, Bal	urnore, MD	2122	3			
Registr		JUN 2 8 2012 Serve B. parks										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 06 Physician/ 20<sup>rear</sup>2 9:02 AM Beatrice Rosser Kennedy 24 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4021 Echodale Avenue Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days Hours Min 220-38-6765 Director 1 M 2 X F 80 07/15/1931 Virginia 28a-f show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1X Yes 2 No 10f, Zip Code 10g. Citizen of What Country? Funeral 4021 Echodale Avenue 21206 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married by Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: Specify:Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Reeds Drug Store Elementary/Secondary (0-12) College (1-4 or 5+) Cook 8th grade is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H 2 Osborne Rosser Edith E.Martin injury or other traumatic 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tricezette M. Kennedy 4021 Echodale Ave. Baltimore MD. 21206 Baltimore, permit. Page 1 g Department of Ht. Important: If item any injury 20a. Method of Disposition 20b. Place of Disposition (Name of 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/03/2012
Garrison Forest Vet. Cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Owings Mills, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral 4210 Belair Road Baltimore MD.21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ erebral Vasaula disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions If any leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent prednant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 mg jo Day Year Pregnant at time of death No the Unknown g Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an has autopsy performe prior to completion of cause of death? page certificate | 2 No Yes 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 1 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Howe 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After Hospital or Attending work? Natural injury 5 Pending neral Director: A rilled in by the f 2 No Accident Investigation M 1 Yes 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

DHMH 17 Rev 06-2011

State

29b. Signate

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

520

Ave

Easton

005 7644

MFLBIde Suite 2300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#5perffl, G930, 8/7/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2012 Month Robert B. Knock 05 8 55 AM Medical くてい 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE BALTIMORE SINAI HOSPITAL OF CITY 5. Social Security Number 4 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Country) Director 217-16-<del>4677</del> XIX M 2 IF 90 Maryland in then "neturel", or Items 23e or 28e-f show the Medical Evaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2XXVo Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Campfield Rd. Apt. 2-G U.S.A. 21207 12. Was Decedent Ever in U.S. Armed Forces?

\*\*N X Yes 2 □ No If Yes, Give Year or Dates. WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian δ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3XXWidowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) flied within 72 el Hygiene. d other then " 2121 Elementary/Secondary (0-12) College (1-4 or 5+) 12 Engineering Manager Electrical with end Mentel Hygie 27 is marked other reumetic event, if Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit, Page 1 end 2 should be Depertment of Heelth end Ment Importent: If Item 27 is marke, eny injury or other treumetic a Charles M. Knock, Sr. Olive Elizabeth Bowers 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Potter/ 829 Ivydale Ave. Reisterstown, MD 21136 Baltimore, 20b. Place of Disposition (Name of A I I F a 1 ths Date 20c. Location - City or Town, State 1 ☐ Burial XXX Cremation 3 ☐ Removal from State 6/29/12 4 ☐ Donation 万☐ Other (Specify) Manchester, MD rematory & Chapel . Signature of word Sovice Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills,MD21117 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ KECURRENT **LFFUSION** LEURAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner HEART LYEARS FAILURE CONGESTIVE Sequentially list conditions, Due to (or as a consequence oi). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events effer death.

Unrector: After this certificate has been signed by the attending physicien end in by the funeral director, page 2 should be deteched for use as the buriel-trensit Exami 3YEARS DISEASE ARTERY or Attending Physicien: The law requires that the death certificate be executed ORONARY Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à - HYPERTENSION - ATRIAL FIBRILLATION Completed 1 Yes 2 No 3 Probably 4 W Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No SLEEP APNEA OBSTRUCTIVE 24a. Was an autopsy performed OBSTRUCTIVE CHRONIC PULMONARY To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and litle of certifier 29c. License number 29d, Date signed (Month, Day, Year) RES-000 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE GOSAIN, MD SINA HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 28 2012 barks Registrar

KOBERT

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PATIENT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Howard Grover King Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital N/A 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 237-22-7884 **Funeral** Days Director 1 X M 2 | F 90 11/22/1921 N. Carolina or 28a-f show 10a. State death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director WV N/A Sheppardstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 33 Shaw Place 25443 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin any injury or other traumatic event. 1 Yes If Yes, Give 2 **X**No 1 Yes 2 X No Specify: Baltimore, Maryfánd 21215-003 Completed 3 ₩ Widowed 4 □ Divorced Specify: Black Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade College (1-4 or 5+) Sales Clerk Hardware Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry S. King Emma Malloy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathaniel King(Grandson) 33 Shaw Pl., Sheepardstown, WV 25443 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State on-site Crematory Conation 5 Other (Specify) Baltimore, MD 1. Signatu e of Funeral Service Joseph Adrs of Brown Jr. Funeral Home PA 2140 N. FUlton Ave., Baltimore, MD 21217 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or yeart failure. List only one cause or each line. A vart 1. Enter the disease, or cor shock, or leart failure. List only immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After the death of the second of the funeral Director After the death of the second of the funeral Director After the second of the use as the burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Yes 2 No be detached Unknown 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No after death.

Director: After this certificate | 1 Yes 2 No filled in by the funeral director, 25. Was case referred to III dical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signaty 31. Date filed (Month, Day, Year, State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ 2012 4:15 A.M Kleinsmith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Baltimore Stella Maris Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral (Month, Day, Year) Days Hours 214-20-0811 87 Director 1 □ M 2 🕅 F Apr17,1925 Maryland item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location Director 1 Yes 2 No Forest Hill Harford Md. 10g. Citizen of What Country? 10e. Street and Numbe Funeral 21050 U.S.A. 106 Gwen Drive, Unit H 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) Payrol1 Betting Equipment Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ၉ Wisniewska Franciszka John Sakowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1023 Green Acre Road Towson, Md. 21286 19a. Informant's Name/Relationship (Type, Print) Louis Kozlakowski-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Stanislaus Cem 20a. Method of Disposition 20c. Location - City or Town, State June®ate 1 X Burial 2 Cremation 3 Removal from State 27,2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA . Signature of Fun ral Service Licensee 1201 Dundalk Avenue Baltimore, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or injury Division of Vital Records, P.O. Box 68760 68 that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 IDOA 1 ☐ Yes 2 No မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month JUNE 2012 25 4:45 A M ROTHSCHILD KATZ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ATRIUM VILLAGE OWINGS MILLS BALTIMORE If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year\_ 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Min (Month, Day, Year) Hours **Director** 071-32-2706 1 🗆 M 2 🛛 F 74 07/07/1937 NY Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 🗆 Yes 2 😾 No MD BALTIMORE OWINGS MILLS 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a 4730 ATRIUM COURT, #379 21117 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Deceden... Armed Forces? ¹ ☐ Yes 2 No Black, White, etc. ō Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: "natural", 3 X Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) **JEWISH** Elementary/Secondary (0-12) College (1-4 or 5+) SECRETARY COMMUNITY CENTER and Mental Hygier is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ FERDINAND RAFFO MARY DITATA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important. If item 27 is any injury or other trau once. EDINA STOLLER/DAUGHTER 2202 SHEFFLIN COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LEBANON CEMETERY 06/27/2012 ADELPHI, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Michail 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complic from that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final o ncesti Physician/ disease or condition Longstandic Medical Examiner resulting in death) Due to (or as a conseque ce of) Sequentially list conditions, if any leading to him claim cause. Enter Underlying Examiner Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 the nding <sub>I</sub> use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ó Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown P.O. Part II. **Other significant cond<u>i</u>tions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Renul Jailuse þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No ဂ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

State Registrar

To the Hospital within 24 hours a To the Funeral I

Medical

29a. Certifier

3 🗌

28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

54118

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2012 Year 25 Shawn Donald Lovley June 6:40 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 8610 Fluttering Leaf Trail Unit 403 Anne Arundel Odenton 6. Sex 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours **Director** 048-40-9250 1 🛛 M 2 🗆 F 51 July 27, 1960 | Connecticut Usual Residence of Decede 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No |Maryland Anne Arundel Odenton 10f. Zip Code o 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 8610 Fluttering Leaf Trail Unit 403 United States items , death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. 1 Never Married 2 X Married "natural", or ģ Yes 2 XNo Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) th and Mental Hygiene.
27 is marked other than traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Writer Theater 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e once. Donald R. Lovley Sylvia Shepard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8610 Fluttering Leaf Trail Unit 403 Odenton, MD 21113 Mary F. Lovley / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date June 26, 2012 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Arundel Crematory Odenton, Maryland Signa are of Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Raw CANCER Physician years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at Id be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 page 2 2 🖪 No 1 Yes or Attending Physician: filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10052089 -25-2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #330

Registrar

DHMH 17 Rev 06-2011

State

28

32. Registrar's signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lake 201 11:53 <u>Deborah</u> Lynn Medical June 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Joseph Richie Hospice House Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days (Month, Day, Year) Hours Min. Director 203-46-0770 1 □ M 2 🛛 F 54 06/05/1958 Maryland Usual Residence of Deceden 28a-f shov 10a. State 10b. County in than "netural", or Items 23e or 28a-f sho the Medical Exprinter must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Directo 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1117 South Clinton Street 21224 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married ۾ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 X Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Business Logistics Engineer Be permit. Page 1 and 2 should be file. Department of Heelth and Mental Humportent: If Item 27 Is moreny Injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Isner Charles Martin Betty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin Wade Bell / Brother 1843 Oklahoma Avenue NE, St. Petersburg, FL 33703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Anatany Gifts Registry 06/28/2012 Hanover, Maryland Anatomy Gifts Registry 21. Signature of Fun - Service Lingsee 22. Name and Address of Facility 7522 Connelley Dr. Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ GASTROINTESTINAL disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Puneral Director: After this certificate has been signed by the ettending physician end ettely filled in by the funeral director, page 2 should be detached for use as the burlal-transit Exam Due to (or as a consequence of) resulting in death) Last Physiclan/Medical Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 🗌 Yes 2 🗆 No Yes 2 No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 L NO မှ 1 Inpatient 2 ER/Outpatient 3 DOA of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 Natural injury Division 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the Hosp within 24 hou To the Funer completely fi only one) 29b. Signature and title of certifier 261 20/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

GWENDOLYN LIPFORD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

unk unk State of Maryland / Department of Health and Mental Hygiene 2012 20595 1- For State Certificate of Death Registrar Reg. No 2. Date of Death

Month 9 Day

June 8, 2012 1. Decedent's Name (First, Middle,Last) Physician/ 3. Time of Death Medical Examiner Gwendolyn Christina Lipford 0305 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Interstate 495 on the Woodrow Wilson Bridge Oxon Hill Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Washington Country D. C. Months Hours Min. Director 579-17-0910 1 M 2 X F 22 August 6,1989 Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show notified at once. 1 X Yes 2 No permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mortal Hygiens Department of Health and Mortal Hygiens "astural", or items 23a or 28a-f sho Important: If item 27 is marked other than "astural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once, Maryland Prince Georges Fort Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 13024 Clarion Drive 20744 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc 1 X Never Married 2 Married 2 X No Yes **Black** 4 Divorced If Yes, Give Yaar 1 Yes 2 No specify: Specify: \$ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Prince Georges Community College 2 years College Student 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert Copeland Ingrid Michelle Lipford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20032 Ingrid Michelle Lipford (Mother) 860 Southern Avenue, S.E.; Apt. 102; Washington, D.C. June 25, 2012 20b. Place of Disposition (Name of cemetery, timore, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State crematory or other place) Beltsville, Maryland Chesapeake Crematory, Inc. 4 Donation 5 Other Specify 31. Signature of Funer 22. Name and Address of Facility R. N. Horton Company Morticians, M01421 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part I. Enter the disease, or comp ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physiciao: The law requires that the death certificate be executed and cai g929 7-6-12 vt attending physician or use as the burial -UNPENDED X AMENDED 2 per me Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death 1 Live birth 3 Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9[ Unknown <u>о</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed of Vital Records, certificate has been 24a. Was an Were autopsy findings available autopsy prior to completion of cause of death? performed' page ✓ Yes 2 No 1 🗸 Yes 2 🗍 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene this 2 ER/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury (Month Day,Year) Jun 9, 2012 After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division Driver auto auto collision Natural 0255 hrs 1 Yes 2 V No Director: d in by the f Pending 2 Accident filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide 6 Could not be or Town, State) Interstate 495 on the Woodrow Wilson Bri, Oxon Hill, MD Within 24 hours a

To the Funeral determined (Specify) Interstate/Express Homicide 29a. Certifier 1 completely Certifying Physician? To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 📝 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 10, 2012 OCME 30. Name and andress of person who completed cause of death (Item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ROBERT JOSEPH LUNN 2012 JUN 0107  $AM^{M}$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death WALTER REED NATIONAL MILITARY MEDICALCENTER BETHESDA MONTGOMERY 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours (Month, Day, Country)
Illinois 1X M 2 ... F Director 361-14-7936 84 Sep. Usual Residence of Decedent 28a-f show 10b. County at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director items 23a or 28a-f s ner must be notified 1 Yes 2x No Virginia Fairfax Vienna 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1726 Abbey Oak Drive 22182 U.S.A. ' death ∿ 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces Black, White, etc. "natural", or ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 2 🗌 1950 If Yes, Give Year or Dates. 1 Yes 2 X No Specify White Specify 3 Widowed 4 Divorced Completed 1980 the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ SAIC Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas Lunn permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Marcellina Chiarella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Louise Lunn/Wife</u> 1726 Abbev Oak Drive, Vienna, Virginia 22182 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Arlington National Oct.3,2012 Arlington, Virginia of Fune A Service Licensee 22. Name and Address of Facility Money & King Funeral Home, Inc. Gary R. Downe Maple Ave. Vienna, Virginia W. CCO 508 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition SEPSIS Medical resulting in death) Due to (or as a consequence of): **Examiner** PNEUMONIA Sequentially list conditions Examine Due to for as a consequence chi if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No ō Month Day Year Pregnant at time of death signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 No 11 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s performed? Yes 2 2 certificate 2X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 X No 1 Tyes မ 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1XXNatural 5  $\square$  Pending work n 24 hours after death.

e Funeral Director: Affolged in by the fur 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MILITARY MEDICAL CENTER, BETHESDA, MD 20889-5600

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

28 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ludd Month 7 - 1 Year Qurana 2:11a м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PG Hyattsville Thomas More 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 218-11-9180 Yrs Director Usual Residence of Decedent 28a-f show 10a. State 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral S.E. 20032 627 Galveston Pl. USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 9 þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: black Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) 2 shoud le filed within 72 lth and ental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Ideal Home Health Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ludd Brenda Copeland Jack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Ludd- mother 627 Galveston Pl. S.E. Washington, DC 20032 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Heritage Cemetery 6-20-12 Waldorf, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal Mortuary . Signatule of Funeral Service Lie Kennedy St Nw Washington, D.C. 23a. I art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cal Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 ast IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 Yes Hospital or Attending Physician: 7 24 hours after death. Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide
4 Homicide М 1 Yes 2 🗌 No Investigation 6 L Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title or certific D006368 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 University Blvd, #208, Hyattsville, Md 20783 Μ Kurup 32. Registrar's Stanature State

DHMH 17 Rev 7/2009

Registrar

12-04263 Daniel Linebaugh Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #5 State or Maryland Department of Health and Mental Hygiene 713/2012 JH 2 20598

		1- For State Certificate of Dea	atn	Reg.	No.			
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			oma Park		Montgomery			
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Director		219-86-7467   1≦M 2□F   48 Yrs.   1151		Aug 29	, 1963 <b>Man</b>	<b>Yand</b>		
	ŀ	Usual Residence of Decedent						
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E		MD Prince George's College F	Park		,	1 Yes 2 No		
Maryland 28a-f show	ē	Transcriber 5 Officer 1	Zip Code	100	. Citizen of What Countr	v? X		
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within rene.	ξĺ	8 painter	1 1000		ome improve			
5-C led v oth			18.Mother's Name	,		<del>-unk</del>		
21215-0036 July be filed within 7 Mental Hygiene. marked other than ic event, the Medical	B	Marshall Dean Linebaugh	Barbara	ı Jean M	lartin			
Mer.		19a. Informant's Name/Relationship (Type, Brint.)	Street and Number of E	Pal Route Number	r City of Town, State	ip Code)		
MD 21215-0036 1d 2 should be filed within 72 hours after death with the Maryland thth and Mental Hygiene. 1n 27 is marked other than "natural", or items 23a or 28a-f sh aumatic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, Brint) O. Debot an Church-sister 900 W. B	Baltimore Stre	et Balti	more, MD	21201		
프 명품 등 등	H	20a, Method of Disposition 20b. Place of Disposition (N	lame of cemetery,		20c. Location - City or To			
S 1.		1 Burial 2 Cremation 3 Removal from State crematory or other place						
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Denation 5 X Other Specify in State						
nit.	1	21. Signature of Funeral Lervice Licepts // 22. Name an	nd Address of Facility					
ii ii De Be iii	1	State Director State	Anatomy Board	1655 W. :	Baltimore S	treet		
Physician	-	23a. Pan.l. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line. Alcohol, Phencyclidin	le of dying, such as cardiac or	respiratory arrest	, shock, or heart	Approximate Interval		
Priysiciali				ne Intoxi	cation	Between Onset and Death		
Examiner	j	Immediate Cause (Final disease a. complicated by chest inj	uries					
		or condition resulting in death)  Due to (or as a consequence of):						
	إ	Sequentially list conditions, b						
	9	if any, leading to immediate Due to (or as a consequence or).			1			
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ed isi		events resulting in death) Last Due to (or as a consequence or):						
executed an and al-trans		d AMENDED AMENDED 23a, pt.II, 27, 28a-f	ner mc c021	0-28-12	Cm Cm			
	/Medical	X UNPENDED	, per me, gyol	)-20 <b>-</b> 12	2111			
760, ficate be g physici the buri	8	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery			
ruffic rug r as th	2	23b. Was decedent pregnant in the past 12 months?	th 3 Ectopic pregna	ncy	Month Day	y Year		
tend tend	:5	4 Pregnant at time of death 5 Other (Sp	pecify)					
Box 687 ne death certific the attending I	Physiciar	1 Yes 2 No 9 Unknown 9 Unknown						
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ires that the signed by lbe detack	Š	Atherosclerotic Cardiovascular Disease		1 Yes	2 No 3 Probat	oly 4 Unknown		
v requires been sign	Completed	Atherosererotte ourdrovasedrar bisease		24a. Was an	24b. Were auto	psy findings available		
ords w requisite the properties of the propertie	ole			autopsy	prior to cor	npletion of cause of		
eco he law ite has	ĔΙ			performe 1 ✓ Yes 2		2 No		
Division of Vital Records, P.O. Box 68760, ral or Attending Physician: The law requires that the death certificate be rs after death.  al Director: After this certificate has been signed by the attending physiciled in by the funeral director, page 2 should be detached for use as the burn		25. Was case referred to medical	26.Place of Death (Check of					
ician icert recto	æ	examiner?   Hospital: 1   Inpatient 2   EP/Outpatient 3	DOA Other Nursin		esidence 6 Other:			
Pysi Tal dir.	၉	Tes 2 No —	28c. Injury at Work?	28d. Describe hov				
1 Of ling Pl After funera	Ë	(Month, Day,Year)			fell down f	light of		
tend tend the f	뜵	2 X Accident Investigation fd 6-4-12 fd 11:00 pm	m	staĭrs				
r At r At irect n by	ည္	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, facto		28f. Location (Stre	eet and Number or Rura	Route Number, City		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide determined (Specify) Residence		College 1	e)4801 Osage Park,MD.	ot.		
ospii hou uner		29a, Certifier , Continue Physicians To the best of my knowledge, death occurred at the	the time, date and place, and					
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in I	my opinion, death occurred a	t the time, date an	d place, and due to the	cause(s)		
To th Withi To th	9	and manner stated.						
	Σ	29b. Signature and title of certifier	29c. License number		29d. Date signed (Month	i, Day, rear)		
		1)-2	O.C.M.E.		June 6, 2012			
		30. Name and address of person who completed cause of death (Item 23a)						
		Donna M. Vincenti, MD Assistant Medical Examiner 900 W. B.	Baltimore Street, Baltim	nore, MD 2122	23			
		24 Data Stad (March Day Voor) 32 Panistrar's Signature						
	tate		/					
Regis	trar	JUN 28 2012 / June 6. March						

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Christopher Lee L	-	State of Maryland / Department of Health and Mental H	ygiene	201	
Diversity in		1- For State Certificate of Death  1. Decedent's Name (First, Middle, Last)		g. No.	
Physicia Medical Examin		Christopher Lee Lyles	2. Date of Death Month June 25, 2	Dav Year	3. Time of Death 1326 hrs
1		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. County of Death	
		2008 Whittier Avenue Baltimore		N/A	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs		h(MM/DD/YYYY) 9. Birt Foreig	
Director		215-80-1565 1 Mm 2 F 51 Yrs.   Months Days Hours Min	12/25	5/1960 Go	untry) MD
<b>A</b>		Usual Residence of Decedent  10a. State 10b. County 10c. City. Town or Location			
ow any					10d. Inside City Limits  1 Yes 2 No
Aaryland 28a-f show Lat ooce.	흲	MD N/A Baltimore  10e. Street and Number 10f. Zip Code		g. Citizen of What Cour	
or 28	Director	2008 Whittier Ave. 21217	"	U.S.A.	
1215-0036 de filed within 72 hours after death with the Maryland fental Hygiene. sarked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at occ.	듄	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-		
death r	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		White, etc.	,
after all", o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Specify: Bl	ack
hours natur		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of votant during most of working life. DO NOT use retired to the complete of the		16b. Kind of Business/li	ndustry
36 in 72 han dical	Completed	College (1-4 or 5+)	,	Super <del>Ma</del>	rket
-000, I with I with	틹	17. Father's Name (First, Middle, Last)  18. Mother's Name  18. Mother's Name	(First Middle M		TVGT
21215-0036 Uld be filed within 7 Mental Hygiene e event, the Medica	8	D	Tuck	aldon odmana)	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-fah.	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F	Rural Route Numl	ber, City or Town, State,	Zip Code)
MD d 2 sh tth and tth and uma at	-	Vanessa Gordon(sister) 8903 Greens Lane,	Randal	lstown, M	D 21133
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 37 is marked other than injury or other traumatic event, the Medicinal events.	-	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Page Page nent o			NK	Baltimor	e, MD
Salt ermit. epartr nport	1	21. Si nature of Funeral Service Licensee 227 Wassend Andrews of Bacilly wn	Jr. Fu	neral Hom	e PA
	¥	2140 N. Fulton 25a. Part I. Enty the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o	Ave.,	<u>Baltimore</u>	
Physician /Medical	9	failure. Vist only one cause on each line			Approximate Interval Between Onset and
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	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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eath certific	<u> </u>	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregna	incy	Month D	ay Year
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that the d the detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to t	he cause of death?
B, P	<u>g</u>		1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
ords, P w requires t us been signs should be d			24a. Was al		opsy findings available empletion of cause of
Reco The law cate has	Completed		perform	med? death?	
Vital Recysician: The director, page	8	25. Was case referred to medical examiner?			
Vital	<u> </u>	1 ✓ Yes 2 No	g Home 5 🗌 🛱	Residence 6 🗸 Other:	Scene
Division of Vital Records, and or Attending Physician: The law requiring a father death.  al Director: After this certificate has been similar to be the fineral director, page 2 should the fine of the father director, page 2 should the fine of th		27. Manner of Death 28a. Date of Injury (Month, Day,Year)  28b. Time of Injury 28c. Injury at Work?	28d. Describe ho	ow injury occurred	
SiOI Vitten death death sctor:	Certification:	2 Accident Investigation			
Divis	Ě۱	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta	treet and Number or Rur ate)	al Route Number, City
hour hour		29a, Certifier	4-1-1-1		
Division of  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After I coppletely filled in by the funeral	Medical	one 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To witi	Σ	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mon	th, Day, Year)
184		( Caberry) O.C.M.E.		June 26, 2012	
V	ŀ	30. Name and address of person who completed cause of death (Item 23a)			
\		Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, M.	MD 21223		
Star Registra	~	31. Date filed (Month, Day, Year)  JUN 28 2012  32. Jegistrar's Signature  June 2. January			
Registra	يالن	JUN GO CUIC   CERUMO PO. PT			

OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death <u>2</u>3<sup>Day</sup> Physician/ 2012 4:45P M Timothy Ray Laquay June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Devlin Manor Nursing Home Cumberland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Director 216-40-7081 1 X M 2 □ F March 27,1943 69 MD Usual Residence of Deceden 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits at Director er than "natural", or items 23a or 28a-fs the Medical Examiner must be notified 1 🗌 Yes 2 🔀 No MD Cumberland Allegany 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 10301 Christie Rd. 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pe 1 and 2 should be filed within 72 I t of Health and Mental Hygiene. If item 27 is marked other than "n or other traumatic event, the Medi Elementary/Secondary (0-12) College (1-4 or 5+) Residential & Electrician Commercial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, P Robert Reginald Laguay Susan Elizabeth Fincham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 1 and 2 st of Health a If item 27 is Timothy D. Trumbull - son 9205 Grant Ave., Luarel, MD 20723 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, crematory or other place) 1  $\square$  Burial 2  $\mathbf{X}$ Cremation 3  $\square$  Removal from State All County Cremation 7/2/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Big tun of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home ofhus 404 S. Main St., Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician cetherschute rent cleseon disease or condition Medical resulting in death) Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Exami Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be-Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? þ 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been si should 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? certificate Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural Accident
Suic 5  $\square$  Pending work?
1 Yes 2 No ithin 24 hours after death.

• the Funeral Director; Af

• ompletely filled in by the fu Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [ within 2

To the comple 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

Weti

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

ATBOILING

JUN

31. Date filed (Month, Day,

28 2012

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LIUZIE, ADLIGOZ

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			1. Decedent's Name (First, Mide	dle I ast)		Cei	inicate of L	Jeani	2. Date	Reg. I	No.	1	3. Time of Death	-
	Physicia								Monti June	1 [		ear	9:12 a M	
	Medic Examin		Catherine Mc 4a. Facility Name (if not institution				4b. City, Town, or	Location			4c. County of		J.12 a	_
ز	Examin	er	Patuxent Rive		rsing	Ctr.	Laurel				Prince	Geo	orge	
	Funeral		5. Social Security Number	6. Sex 7. Ag		ast birthday)	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of Mont	of Birth	r) 9	Birthpla	ace (State or Foreign	Ī
	Director	2 kg	212-36-8563	1 □ M 2 🔀 F	83	Yrs.	IVIONITIO DIAJO		Oct.	25, 19	28		MD_	_
	nd now	1 h	Usual Residence of Decedent  10a. State 10b. Coun	ity	10c. City	y, Town or Lo	cation					10	d. Inside City Limits	_
	arylar a-fsl	Director	MD Prin	ce George	La	urel							1 🔀 Yes 2 🗆 No	)
	or 28	ă	10e. Street and Number	00 000290			10f. Zip Code			10g.	Citizen of Wh	at Countr	ry?	
	with s 23a	Funeral	702 Gorman Av	e., T-2			20707			USA	<u> </u>			_
	death items		11. Marital Status	12. Was Decedent Armed Forces?	)	3. 13.	Was Decedent of H	ispanic Ori an, Mexicar	gin? (Specify Yes o n, Puerto Rican, etc	No-	14. Race - Black,	American		
36	after ( I", or camir	l by	1 ☐ Never Married 2 ☐ M 3 ★ Widowed 4 ☐ Divorce	If Yes, Give	¥No		1 ☐ Yes 2XXNo	Specify:			Specify:	Whi	te	
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nd	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle						er's Name (First, M					
Maryland 21215-0036	uld be I Ment narke natic	-	William M. Al			T			a Virgini	-		4- 7/- C		-
Mar	should h and Me 7 is mar traumati		19a. Informant's Name/Relatio						er or Rural Route N -2, Laure				ode)	
ė,	1 and 2 should be filed within 72 hours after death with the Maryland theath and Mental Hygiene. It health and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.		Helen V. Matc	mett / Niece	20b. F	Place of Dispo	osition (Name of				. Location - C		vn, State	_
nou	age 1 ent of nt: If in y or o		1 Burial 2 Cremation 4 Donation 5 Othe	on 3 Removal from State	5	-	natory or other place ndel Crei	i	2012	1	lenton,	MD		
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service		1				tyDonaldso				P.A.	_
ñ	and be	8.	I Ken Skit	le MO:	1053	3	13 Talbo	tt Av	e., Laure	1, MD	20707			
- 4	h, i ian/ Medical		23a. Part I. Enter the disease, sheck, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	, or complications that cause st only one cause on each lin a. Due to (or as	ie.	Sder			Wascu	1	Jesean	20	Approximate Interval Between Onset and Death	Ö
-6	Examiner			Due to (or as	a conseq	acrice oi).								
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N.	cuted nd ransit	Examiner	Cause (Disease or iinjury that initiated events	C								$\dashv$		_
Y	e exection and an arrial-t	cal E	resulting in death) Last	Due to (or as	s a conseq	uence ot):								
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Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1  Live Birth 4  Pregnant	2 Fet	al death 3	☐ Ectopic pregnan☐ Other (specify) _	су			23d. Date Mont		ery Day Year	
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Ž	Physical this caracteristics	2	1 Yes 2 No	1 _ Inpa		ER/Outpatie	ent 3 🗆 DOA	4 LBL	lursing Home 5 28d, Des		e 6 ∐ Other njury occurred			-
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Division of Vital Records, P.O.	or Atter after dea Director in by the	Certificate:	3 Suicide 6 Co	uld not be 28e. Place of Ir	njury - At h etc. (Specif	ome, farm, st	reet, factory, office			ition (Street or Town, St		or Rural	Route Number,	
Δ	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2.	Medical	(Chook 2 Medic	ying Physician: To the best of all Examiner: On the basis of ying Nurse Practioner: To the	f examination	n and/or inve	stigation in my opin	ion, death o	occurred at the time.	date and pl	iace, and due t	to the cau	use(s) and manner stat	te
	Fo the within Fo the complex c	Σ	only one) 3 L Certify 29b. Signature and title of cert		io peor Oi II	, mowieuge,	29c. Licens		mile proces tarte do	29d.	Date signed (	(Month, D	Day, Year)	_
	->-0		<b>)</b>	100 C		W.	SD	24	721	1	JUNE	26	JU 2012	_
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	0		SYEN A.	SASIQ 14	1332	Lau	rel Bowi	e k	Cal. St	208	LITTIK	E-L	MD2070	)

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Donna Lynne McDaniel Manley 2012 24  $P^{M}$ <u>June</u> 6:45 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey's House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Director 1 □ M 2 💢 F 61 9/24/1950 Alabama shov 10b. County ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15104 Bitterroot Way 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene, I other than " Non-profit Elementary/Secondary (0-12) College (1-4 or 5+) 12 Health Educator Medical Reserch Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant: If item 27 is many Injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clem H. McDaniel Ester Clyte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy Manley / Husband 15104 Bitterroot Way, Rockville, Maryland 20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/27/2012 Atlantice Crematory Glen Burnie, Maryland sign ture of Funeral Service Liceose 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Immediate Cause (Final Onset and Death Physician/ disease or condition End Stage Liver Disease vears Medical resulting in death) Due to (or as a consequence of) Examiner Cirrhosis vears Sequentially list conditions, if any, leading to immediate cause Enter Underlying Due to (or as a consequence of). sician and burial-transit Exami Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ō in the past 12 months? The law requires that the death 5 Other (specify) Month Day Year signed by the at Yes 2 No 9 Unknown 9 Unknowń P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ å of Vital Records, cate has been siç ; page 2 should t Completed 1 Tes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 XOther (Specify) HOSpice 1 ☐ Yes 2 🌠 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu Division 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0060634 6/25/2012

DHMH 17 Rev 06-2011

State

Registrar

Bindu Joseph, MD 6001 Muncaster Mill Road, Rockville, MD 20853

barks

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 Rose Milosevich June 21 10:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3128 Helsel Drive Silver Spring Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Hours (Month, Day, Year) 11.15,1923 Ohio Director 301-20-1940 88 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗆 Yes 2 🙀 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3128 Helsel Drive 20906 U.S.A. ural", or items? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. Completed by 1  $\square$  Never Married 2  $\square$  Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", White Yes, Give 3 X Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Petar Milasnovich Ljubica Osterjas and 2 should be Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milorad Milosevich/Nephew Loree Drive, Rockville. injury or other Maryland 20853 item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot cemetery, crematory or other place) tX☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 4 ☐ Donation 5 ☐ Other (Specify) June 30,2012 Silver Spring, Md. 21. Signal ve of Funeral Service Licensee 22. Name and Address of Eachilty Money & King Funeral Home, Inc. Gary R.Downer Nau CCO 508 ., Vienna, W Maple Ave 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician HITHEROS diovascular disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of) resulting in death) Last burial attending physician for use as the burial Physician/Medical requires that the death certificate be Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant a Day Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 D P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 🗌 Yes 2 X No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should h 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an Hospital or Attending Physician: The law autopsy performed? Yes 2 N 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury Natural 5 Pending Accident death. 2 🗌 No Investigation within 24 hours after death

To the Funeral Director: A Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) 29b. Signature and title of certifier Name and address of person who completed cause of ceath (Item 23a) CId 0M9 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 00 PM J. Norma Moog Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Baltimore Franklin Square Hospital Ose 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) WVA If Under 24 Hrs. 8. Date of Birth **Funeral** . Social Security Number 216-44-0627 May 24 . 1932 **Director** 80 yrs. 1 □ M 2**X** F or 28a-f show 10a. State items 23a or 28a-f sho ner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore Essex MD 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 38 Rockywood Lane USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify: "natural", Completed 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Bar Maid Bar 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental မ Blanche L. Roubough Frank Puffenbarger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
38 Rockywood Lane Baltimore MD 21221 Department of Health ar Important: If item 27 is any injury or other trauonce. Alfred J. Moog Jr. /son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 \*\*Cremation 3 \*\*Removal from State cemetery, crematory or other place) 6/27/12 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory eral Service 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ End Stag disease or condition Medical resulting in death) Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 2 🗌 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď Hypertension, Arthriti 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy death?
1 Yes perform within 24 hours after death.

To the Funeral Director: After this certificate 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore lin Square Drive

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 20605 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Brisa Marquez Elizabeth 2012 June 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Mont Adventist Grove omer HOSpita If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1 M 2 XF June (6, 2012 Davs Hours infant Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 🗆 Yes 2 🖫 No Gaithersburg Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 18355 Loss Circle 20886 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: hispanic 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) infant infant infant infant unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sandra Sarauia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shady Grove Adventist Hospital 9901 Medical Center Drive Rockville, MD 20850 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State

> Approximate Interval Between Onset and Death

2 No 3 Probably 4 Unknown

1 ☐ Yes 2 ☐ No

2012

24b. Were autopsy findings available prior to completion of cause of death?

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6

1 🗌 Yes

autonsv performed? 1 Yes 2 No

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

24a. Was an

26. Place of Death (Check only one)

28c. Injury at work? 1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

9901 Medical Center Drive, Pockville, mayland

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Year

Department of Health and Mental Inportant If Item 27 is marked off any injury or other traumatic and once. enysician/ Medical **Examiner** 

nding physician and use as the burial-transit

signed by to

peen

cate has l

certificate

this

within 24 hours after death.

To the Funeral Director: After completed filled in by the funer

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Examiner

**Funeral** 

Director

ms 23a or 28a-f show must be notified at

n "natural", or item ledical Examiner m

the and Mental Hygiene.
It is marked other than traumatic event, the Me

Medical

Director

Funeral

ğ

Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Examine Physician/Medical

by Completed

Be

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Certificate:

Medical

25. Was case referred to medical

2 XNo

5 Pending Investigation

6 Could not be

determined

Burton, HD

examiner?

1 🗌 Yes

27. Manner of Death

1 Natural

Accident

Suicide

4 Homicide

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

4 Li Donation 5 12 Other (5)	oechy) in state		
21. Signature of Funeral Service Li	. Director	22. Name and Address of Facility State Anatomy Board 655 W. Ba Baltimore, MD 21201	ltimore Street
23a. Part 1. Enter the disease, or shock or heart failure. List of Immediate Cause (Final disease or condition resulting in death)		enter the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Betv Onset and D
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a consequence of):		
that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy  1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Y

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of injury (Month, Day, Year)

Registrar's Sign

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Durane Ellicit Malloy  Trysocion	12-04268	llov	amend	ease <sub>9</sub> Type	or Print in B	lack Ind	elible l	nk. En	sure	ALC OF	es Are	639ib	<b>A</b> 4	110	2000
Privacion Medical Examinor  The County Name (First, Mode), and Suppose the County of County Name (First, Mode), and Suppose (Name of County of County Name (First, Mode), and Suppose (Name of County of County Name (First, Mode)), and suppose (Name of County of County Name (First, Mode)), and suppose (Name of County of County Name (First, Mode)), and suppose (Name of County of County). The County Name (First, Mode) (Name of County) (Name of Count	Duane Elliott Ma	·	1- For State	Stat	e or Maryland					i wentai r	nygiene			112	2060
Howard County General Hospital  5. Social Security Numericanal 6. Same  17. April (ny ns. total britishouly)  12.8-76-0977  17. Max 2			Duane	e Elliot	t Malloy_			4h City To	own or l	ocation of Dea	June 8	Day 5, 2012		141	
218-76-0977   MM			•			,		•		Education of Education		- 1		Journ	
To Size and Number								Months	_	+	n.		F	oreign	unk
MD Anne Arunde1 Jessup 10.2 pcde 10.	шу					10c. City, To	own or Loca	tion						10d. Ins	de City Limits
Approximate interval   State   Approximate	and show a	<u>اة</u>	MD	Anne A	runde1	Je	essup							1 🗌 Y	es 2 No
Approximate interval   State   Approximate	Maryli r 28s-f	irect						10f. Zip C	Code			10g. Ci	tizen of What	Country?	
Approximate interval   State   Approximate	s 23a o					t Ever in U.Ş.	1 13. W				Specify Yes	or No-			n, Black,
Approximate interval   State   Approximate	death v	une	1 Never Marr	ied 2 Marri	ed Armed Forces		III.		Cuban,	Mexican, Puer	o Rican, etc	.)	White, e	etc.	
Approximate interval   State   Approximate	rs after ural", miner	á			or Dates:	mpleted) 1	6a. Decede	7	Δ		work done	16b.			
Approximate interval   State   Approximate	72 hou	leted	Elementary/Sec	ondary (0-12)		5+)	during n	nost of work	ing life. I			ık.			
Approximate interval   State   Approximate	003( within giene.	dmo	unk			0	Cai	_	11	8 Mother's Nan	o (First Mid			nproven	ent 
Approximate interval   State   Approximate	215- be filed ntal Hyg					Sr.		<del>-ur</del>	nk   "				r ourname,		unk
Approximate interval   State   Approximate	D 21 should I is man					. 1	5408	3 Delr	ay l	Dr. Wil	Rural Route	Number, On, De	19808	State, Zip Cod	∍)
Approximate interval   State   Approximate	and 2:stealth a				Malloy-br	20b. Pla	9 <del>00 1</del> ace of Dispo	V Ball sition (Name	E im	ore Str	eet Ra	1time	TE MI	ty or Town, IIIa	<del>Q</del> i e
Physician   Medical Examiner	MOF Pages 1 ent of I			_	_	tate cre	ematory or o	tner place)		4		V.			
Physician   Medical Examiner	Saltil ermit. Separtm mports ajury o	Ì			anena/ /	rector	- 22. St	Name and A	Address on a to	of Facility my Boar	cd 655	W. B	altimo	re Stre	eet
Medical Examiner  Table 1. Examiner  Table 1. Examiner  Table 1. Exposure of the standard of t		-				the death. D	Ba o not enter	1timo the mode of	re dying, s	MD 21 such as cardiac	On respirator	y arrest, sh	ock, or heart		
The condition resulting in death)  Due to (or as a consequence of):  Due t	/Medical	-				with c	omplie	ation	ıs					Betwe	
The state of the s	LXammer	-		ng in death)											
AMENDED 23a,27,per me,g931 9-10-12 sm    Section   Part		ē	if any, leading to in	nmediate	Due to (or as a cons	equence of):									
AMENDED 23a,27,per me,g931 9-10-12 sm    Section   Part		xam	(Disease or injury	that initiated	Due to (or as a cons	sequence of):									
FEMALE:   23d. Date of delivery   23d. Date of Date		- F	T LINDENDER		d.	Ba. 27. p	er me	. e931	9-1	0-12 sm	1				
28b. Was decedent pregnant in the past 12 months?    Test   Test	60, ate be e physicia	Medi	IF FEMALE:					76,5-				23	3d. Date of de	livery	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	OX 687 sath certific attending p	sician/	past 12 month	s?	4 Pregnant a	t time of death	=			Ectopic pregr	nancy	_	Month	Day	Year
The state of the s	O. B at the da 11 by the		Part II. Other sign	ificant condition		th but not resu	ulting in the	underlying c	cause giv	ven in Part I.	23e. I	Oid tobacco	use contribu	te to the cause	of death?
248. Was an autopsy performed?   1	S, P.	ed b											1450 3740		
25. Was case referred to medical examiner?  1	cord law req has bee	pet										autopsy	prio	r to completion	
examiner?    Nursing Home 5   Residence 6   Other:	Rec r: The dificate or, page		25 Was case refer	red to medical	T			26	S Place o	of Death (Chec	1 🗸			Yes	2 No
27. Manner of Death  1	Vita ysicia this cer	ďΙ	examiner?	_	Hospital: 1 / Inpati	ent 2 El	R/Outpatien			Ythor: -		Resid	ence 6	Other:	
Second Process of the Control of t	n of ding Pl	Ë			(Month, Day,	ury 2 rear)	8b. Time of				28d. Desc	ribe how in	jury occurred		
Suicide  4 Homicide  4 Homicide  29a. Certifier (Check only)  29a. Certifi	isio	licati		Investig	ation 28e Place of I	njury - At hom	e, farm, stre						and Number of	or Rural Route	Number, City
29a. Certifier (Check only one) 29a. Certifier 29a. Certifier 29a. Certifier 3 29a. Certifier 3 29a. Certifier 4 29a. Certifier 3 29a. Certifier 4 29a. Certifier 4 29a. Certifier 5 29a. Certifier 5 29a. Certifier 6 29a. Certifier 6 29a. Certifier 7 29a. Certifier 7 29a. Certifier 8 29a. Certifier 8 29a. Certifier 9 29a. Certifi	Div pital or ours aft ceral Di	Series	4 Homicide								or To	wn, State)			
and manner stated.	the Hos in 24 h the Fun pletely														)
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	To t With To c	Med													
Theodor We King The Man D. O.C.M.E. OCME June 6, 2012			The	du W	King.	TR.	λ.,		O.C.M	1.E.	CME	Jur	ne 6, 2012		
30. Name and address of person who completed cause of death (It in 23a)  Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223		ţ			170			900 \^/ 5	Saltim	ore Street	Baltimore	MD 213	223		
State 31. Date filed (Month, Day, Year)  Registrar  11. Date filed (Month, Day, Year)  22. Registrar's Signature	St	ate	31. Date filed (Mon	th, Day, Year)	2. Registra							, 212			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J™ne 11:45AM 2012 Frances С. Matuszak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 3210 Honeysuckle Lane Middle River 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8 Date of Birth **Funeral** Nov111, 1913 Maryland 218-07-3394 98 **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Middle River Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 3210 Honeysuckle Lane 21220 U.S.A. should be filed within 72 hours after death and Mental Hygiene. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 7th Seamstress Sewing Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Rozanski Joseph Lejsiak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 Honeysuckle Lane Middle River, 19a. Informant's Name/Relationship (Type, Print) Md21220 Tommy Thomas/ Care Giver 1 and 2 s of Health item 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JuneDate permit. Page 1 a
Department of H
Important: If ite
any injury or oth 1 ♥ Burial 2 Cremation 3 Removal from State St.Stanislaus Cem 27, 2012 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Lice M00933 Dundalk Avenue Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NASTING Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and ched for use as the burial-transit that initiated events resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the businessed filled in by the funeral director, page 2 should be detached for use as the businessed. Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home 5 \( \frac{\frac{1}{2}}{2}\) Residence 6 \( \sum \) Other (Specify) 2 XNo မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) June 25, 2012 D 15904 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Stephen D. Nightingale, M.D. 705 Digital Drive, Ste G.Linthicum, Md 0 State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Phillip Jeffrey Merson

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		1- For State Registrar		Certific	cate of	Death			R	eg. No.	hou	0 1	
Physic	ian/	Decedent's Name (First, Middle)	e,Last)						Date of Dea Month	th Day	Year		3. Time of Death
<sup>⊮</sup> ≏dical Exam	iner	Philip		rson					June 23, 2	2012			1507 hrs
		4a. Facility Name (if not institution Queen Anne Emerger			44	o. City, Town, or Lo Queenstown		Death			c. County of Queen A		
Funera		5. Social Security Number	6. Sex 7. Age (	In yrs. last bir	rthday)	If Under 1 Year	If Under		3. Date of Bi	rth (MM	/DD/YYYY)	9. Birth Foreign	place (State or
Director		219-64-8458	1 X M 2 F	59	Yrs.	Months Days	Hours	Min.	April	28,	1953		ntry) MD
any		Usual Residence of Decedent  10a. State 10b. County	11	0c. City, Towr	n or Locatio	n						1	10d. Inside City Limits
<b>.</b>	ō		rroll	Wes	stmin								1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 779 Lone	Tree Rd.			10f. Zip Code	21157	7		0g. Cit	U.S.		ry?
hours after death with the Maryland "natural", or items 23a or 28a-f she Eaminer must be notified at once	Funeral	11. Marital Status 1 Never Married 2 X M	12. Was Decedent Evarried Armed Forces?	ver in U.S.		Decedent of Hispa s, specify Cuban, I				)-	14. Race - White,		an Indian, Black,
ther d		3 Widowed 4 Div	orced If Yes, Give Year or Dates:	7 NO	1 🗆 🕻	res 2 X No	specify:				Specify:	Whi	.te
ours a satura xamin	d by	15. Decedent's Education (Spe-	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Decupation (Give kind of work done during most of working life, DO NOT use retired)										dustry
2 3 -	ompleted	Elementary/Secondary (0-12)	College (1-4 or 5+	·					,	01	-ato (	70-70	rnment
15-0036 filed within 72 Hygiene. d other than "	Шo	12 17. Father's Name (First, Middle,	5+		POTIC	eman/tro	-	Name (Fi	irst, Middle,			JOVE	Limenc
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	BeC	John Warre	•						Bald		,		
D 21218 should be file and Mental H 7 is marked on antic event, 1	10	19a. Informant's Name/Relations	hip (Type, Print )		_	Address (Street	and Numb	per or Rura	al Route Nur	nber, C	-		
MD d 2 sho lith and n 27 is	П	Denise B. Mers	son – wife			one Tree							
ore, MD ; set 1 and 2 shou of Health and 1 if item 27 is the traumatic	П	20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from State		of Dispositi atory or othe	on (Name of ceme er place)	etery,	D	ate	20c.	Location -	City or T	own, State
Fag Pag nent		4 Donation 5 Other Sp			anore	Cemetery	7	6/28,	/2012	U	nionv	ille	e, MD
Baltimore, permit. Pages I ar Department of Hez Important: If ite injury or other tr		21. Signature of Funeral Service	// 1//			me and Address of Church							
Physician		23a. Part I. Enter the disease, or	complications that caused th	e death. Do n				•					Approximate Interval
Medical	١.	failure. List only one cause	on each line.										Between Onset and Death
Examine		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	uence of):								_	
7)	اد	Sequentially list conditions,	b									_	
ł,	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence.	uence of):									
and und transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	uence of):									
760, cate be execut physician and the burial - tran	1 22 1	UNPENDED	AMENDED										
760, ficate be physici the buri	/We	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome 1 Live birth			Il death 3	Ectonic	pregnancy	,	23	d. Date of o	delivery Da	av Year
Box 68: e death certiff the attending ed for use as t	Physician	past 12 months?	4 Pregnant at tir			er (Specify)	_Ectopic	pregnancy	,		MOUNT	De	y rour
<b>BO</b> ; le deat the at the at for			known 9 Unknown						Las stu		4.51		(1-110
Records, P.O. Box 68760,  The law requires that the death certificate be executed reate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	ρ	Part II. Other significant condit	ions contributing to death b	out not resultir	ng in the un	derlying cause giv	en in Par	t I.		_	_		ne cause of death?
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of Vital Records, ing Physician: The law require After this certificate has been simmed director, page 2 should by	1 =	12				_			autop perfo 1 <b>✓</b> Yes	rmed?	de	eath?	mpletion of cause of
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of Vital   ing Physician: After this certifi uneral director,	0	1 ✓ Yes 2 No		2 <b>V</b> ER/C					lome 5			Other:	
F 22 . ~ 42	<u></u>	27. Manner of Death  1 Natural 5 Pend	28a. Date of Injury (Month, Day,Yea ding FOUND:	r) FO	. Time of Inj UND:		es 2. ✔ I	lDr	d. Describe river of me				ard rail and pole
Division tal or Attendi rs after death. al Director:	cat	2 Accident Inve	stigation Jun 23, 2012		10 hrs farm, street				f. Location (	Street	and Numbe	r or Rura	al Route Number, City
Divising pital or At tours after diving a fired birect filled in by	Certification:		Id not be rmined (Specify) Majo	r Road / H	Highway			Rt	or Town, \$ 50 & Nesb	state) it Roa	d, Queen:	stown, I	MD
Divisior  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		hysician: To the best of my k										
To Witl	Mec	29b. 8ignature and title of certific	and manner stated. er	A	-	29c. License	number			29d.	Date signe	d (Mont	th, Day, Year)
		(0/11	1111	1 4	1	O.C.M	1.E.			Jur	ne 24, 20	12	
$G_{i}$		30. Name and address of person	· · · · · · · · · · · · · · · · · · ·			-1							
			Assistant Medical Exa				t, Baltin	nore, M	D 21223				
	State strar		2012 Registrar's	Signature	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:25P M Donald McCleary 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester 18 Concord Lane Ocean Pines 8. Date of Birth (Month, Day, Yea April 10, Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F 212-22-3396 85 Maryland Director 1927 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland this and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Ocean Pines MD Worcester 1 ☐ Yes 2 Ϊ No 10e. Street and Number 10g. Citizen of What Country? Funeral 21811 U.S.A. 18 Concord Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 It Yes, Give WW II 1 ☐ Yes 2 X No Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Home Builder Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ McCleary, Sr. Ε. Ensor Millard Wesley Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health at Important: If item 27 is any injury or other trau 3715 Meadowhill Ct., Phoenix, MD 21131 Kirk McCleary-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1  ${f X}$  Burial 2  ${f \Box}$  Cremation 3  ${f \Box}$  Removal from State cemetery, crematory or other place) 6/27/12 Black Rock Cemetery : Butler, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate et and Death Immediate Cause (Final Physician CARPIOMYOPATHT disease or condition resulting in death) Medical Due to (or as a consequence of Examiner ASCVD Sequentially list conditions, if any, leading to immediate caus. Litter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) and -tran resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending phi i for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ 3 in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a id be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\nearrow$  Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated M.A. Ph.D. 6-25-12. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOMASZ A. SWIERKOSZ, M.D., Ph.D. 400 EASTERN SHARE DE SUITE 10)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JUN 28 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2012 Physician/ 5:15 PM JUNE MILLER Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** BALTIMORE BALTIMORE #218 1840 REISTERSTOWN ROAD, 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8 Date of Birth . Age (In yrs. last birthday **Funeral** Min (Month, Day, Year) 08/30/1919 1 □ M 2 🗓 F Months 92 **Director** 218-01-5185 Usual Residence of Decedent 10d. Inside City Limits 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items "nany or other traumatin." 10b. County 10c. City, Town or Location 10a State Director 1 Yes 2 X No BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 1840 REISTERSTOWN ROAD, #218 21208 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) EXECUTIVE Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT ISRAEL BONDS Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ GOLDSCHEIDER BESSIE SCURNICK EMMANUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9037 ALLENSWOOD ROAD, RANDALLSTOWN, MD MICHAEL MILLER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
ANSHE EMUNAH AITZ
CHAIM CEMETERY 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 06/26/2012 BALTIMORE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licen 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one layse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 900016 CRITICAL Sequentially list conditions, if any, leading to immediate cause E. d. Huseryng. Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death g Unknown signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 performed 2 No 1 Yes this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural within 24 hours after death. To the Funeral Director: After injury 5 Pending 1 🗌 Yes 2 🔲 No Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

(Check

29b. Signature

30. Name and ac

only one

completed cause of death (Item 23a) (Type, Print)

STERNEW 32. Registrar's

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Certifying Nurse Practioner, To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year)

2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2017 JUNE 12:25P M BERTHA MAY 17 Τ., Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA HOWARD GILCHRIST CENTER If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 579-06-4494 Director 1 🗆 M 2 🗓 F Mar.12,1970 42 Wash.,DC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location items 23a or 28a-f shoner items to be notified at Director 1- Yes 2 □ No Takoma Park Md. Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 20912 United States 6735 New Hampshire Ave. Unit411 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 þ 1 Never Married 2 X Married 1 Yes 2
If Yes, Give
Year or Dates 2 (XNo Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: "natural", B1ack Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Cashier Retail traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Milton K. Hickman Annie Lois Fullard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Cassandra Bradley/Sister 2913 North Capitol St., NE Wash.,DC 20002 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Department of I-Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Waldorf, Md Cemetery 6-26-12 ritage 21. Sign 11 re / Funeral Service Licensee 22. Name and Address of Facility Capitol Mortuary, Inc. Maryland NE 23a. Part 1. Enter the disease, or shock, or heart failure. List of omplications that caused the death. Donly one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final PANCREATIT Physician/ DAYS disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner Due to (or as a consequence of, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ this certificate has been signeral director, page 2 should be PSEUDD CYSTS 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No 24 hours after death.

Funeral Director: After this certifica etely filled in by the funeral director, r or Attending Physician: Tafter death. 25. Was case referred to medical 26. Place of Death (Check only one) Be INPATIENT UNIT. Hospital: Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier To the Hosp within 24 ho To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Oth D0069962 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Joseph Vernon Nagle 2012 6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Raltimore Rosedale Franklin Square Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** . Social Security Number 212-50-5868 Days 1 X M 2 □ F Months Hours 66 April20,1946 Director MD Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, in a Modical Examiner must be notified at 1 ☐ Yes 2€ No Director MD Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 USA 841 Brunswick Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 ☐ Married White 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: Specify 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon C. Nagle Catherine M. Rohrbaugh မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Karczeski 303 Tiree Court Unit 101 Abingdon MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 6/27/12 Date 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 MAce Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a A Cute Gastrointe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): spital or Attending Physiclan: The law requires that the death certificate be executed ours after death.

reral Director: After this certificate has been signed by the attending physician and filled in by the funneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pertension autopsy perform 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

P.O. Box 68760. Division of Vital Records, Hospital 24 hours a To the I within 2

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of certifier

Or Chien ve Nuachinemere 9000 Franklin Square Drive Baltimore, MD 21237
31. Date filed (Month, Day, Year) 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

29c. License number

0063176

29d. Date signed (Month, Day, Year)

6-26 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #25 Per ME G928 6/28/2012 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert K. Odenheimer June 15  $\tilde{2}012$ 7:45 AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Director 164-05-2385 1**X**] M 2 □ F 98 Jan 14, 1914 Pennsylvania Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygene.
The stream 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director 1√2 Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7219 Park Heights Avenue #408 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give 3 Divorced Specify white 41-45 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 should be filed with and Mental Hygien pharmac<u>y rep</u> retai1 Be 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Hugo M. Odenheimer Miriam Rosenblatt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margia Bokobza/daughter 5937 Western Park Drive Baltimore, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 Orger (Specify) Signature of State Anatomy Board 655 W. Baltimore Street Me Director Baltimore, MD 21201 Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gives on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to (or as a somequence on). Hospital or Attending Physician: The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL that initiated events resulting in death) Last Due to (or as a consequence of) burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
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Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 은 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death iours after death.

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To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only on re and title of certifier 29d. Date signed (Month, Day, Year) 581 15000 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript)
PWWP Shaheen, 6701 N. Chaeler St. # 4105, Baltimare, Mi 21204 State JUN 28 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner  900 W. Baltimore Street, Baltimore, MD 21223	Vital ysiciar his cer directo	m	examiner?	Hospital:	patient 2	ER/Outpatient						esidence 6	Other.	Scene
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29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner  900 W. Baltimore Street, Baltimore, MD 21223	r Attener death	licati	2 Accident Inves	stigation 28e Place	of Injury - At ho	ome, farm, street					f. Location (St	reet and Number	or Rura	I Route Number, City
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 June  $22^{Day}$ 4:30 PM Palmisano Salvatore George Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town or Location of Death 4c. County of Death **Examiner** Baltimore n/a 218 South Exeter Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Director 219-32-9890 74 1 X M 2 - F Feb22,1938 Maryland ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Baltimore City Md. 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21202 U.S.A. 218 South Exeter Street permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify. White Year or Dates ed other than "nature event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Pilot Aviation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F item 27 is marked of other traumatic even Mental F ၉ Regina Carosella Salvatore Palmisano 19a. Informant's Name/Relationship (Type, Print) Partner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
218 S. Exeter Street Baltimore, Md. 21202 Miss Patricia Novak 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer 26,2012 Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funera Service Licensee M009331201 Dundalk Avenue Baltimore, Md.21222 Rober 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to jor as a consequence of if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Hospital or Attending Physician; The law requires that the death Month Day Year Pregnant at time of death 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 K Residence 6 Other (Specify) မ 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) June 25, 2012 30. Name and address of person who completed cause 0 of death (Item 23a) (Type, Print) MD 301

DHMH 17 Rev 06-2011

State Registrar Thomas

Registrar's Signature

## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert William Ross Р 2Ó1 1714 Medical Tune 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 315-36-3243 Director 72 1 🛛 M 2 □ F 5, 1939 Indiana Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if item 27 is marked outher than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 ¥ Yes 2 □ No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13119 Forest Drive 20715 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Systems Engineer N.A.S.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Leonard Ross Dorothy Irene Buchanan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Ann Ross - wife 13119 Forest Drive, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☑Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 6-25-2012 ☐ Donațion 5 ☐ Other (Specify) Crematory u etal Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, Maryland 20715 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or a spiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this course. the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ res ∠ □ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an the funeral director, page 2 performed Yes 2 No 1 Yes 2 No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other Certificate: To 1 🔲 Inpatient ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 376

DHMH 17 Rev 06-2011

State

Registrar

JUN 28 2012

2001 Medical

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20 20ั่าิว์ Arlene Runkles June Guyton 1:00 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Kline Hospice House Mt. Airy Social Security Number If Under 1 Year | If Under 24 Hrs **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Hours **Director** 157-01-2826 1 M 2 XF 99 Usual Residence of Decedent Maryland Sept. 22,1912 28a-f show 10a, State 10b. County 10c. City, Town or Location with the Maryland must be notified at 10d. Inside City Limits Director Maryland Carroll 1 X Yes 2 No Mt. Airy 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 Moxley St. 21771 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian þ Black White etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Completed 3 ₩ Widowed 4 □ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) 11 5+ music teacher public schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Page 1 and 2 should be Edgar Garfield Guyton Cora Bowlus 19a. Informant's Name/Relationship (Type, Print) Health and tem 27 is r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion V. Runkles III/ son 18200 York Rd. Parkton, MD 21120 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If its any injury or of once. 1 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 6/23/2012 Prospect Cemetery nr. Mt. Airy, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hartzler Funeral Home, P.A. athan Box 249 New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caus 10th e death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Day Year 2 / No 9 Unknown Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has I autopsy performed' death? 1 Yes Yes 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 110 ٥ 1 Tyes Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 X Other (Specify) hospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide 6 Could not be 3 ☐ Suiciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely only one) 29b. Signature and 29d. Date signed (Month, Day, Year) 126499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ronald E. Miller 4 Culwell Dr. Mt. Airy, MD 21771 31. Date filed (Month, Day, Year) 32. Registrar's Sigrature State 28

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012  $A^{M}$ June 5:16 **JACKSON** RIPPEON RAYUE Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick <u>Frederick Memorial Hospital</u> Frederick Birthplace (State or Foreign Country) If Under Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) **Director** 220-30-9743 1 🔀 M 2 🗆 F Yrs. Apr. 7, 1926 86 Maryland Usual Residence of Deced 28a-f show at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2 No Maryland Frederick Keymar 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 12403 Detour Rd. 21757 U.S.A. items 2 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. "natural", or iten edical Examiner r Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 XMarried Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify Specify: 3 Divorced 4 Divorced White Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 8 farmer agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked c any injury or other traumatic eve once. ည Winfield Scott Rippeon Pearl Virginia Curfman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keymar, MD 21757 Doris J. Rippeon/wife 12403 Detour Rd. Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 6/25/2012 | Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gard. Signature of Funeral Service License 22. Name and Address of Facility Hartzler Funeral Home, P.A. Woodsboro, MD 21798 <u>404 S. Main St.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph\_sici\_n disease or condition Medical resulting in death) Due to (or as con quence of) Examiner Sequentially list conditions Examine If any, leading to homediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 < Hospital or Attending Physician: The law requires that the death certificate be the phy as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the ai 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Deth . Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death. Funeral Director: A Accident Investigation filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical within 24 hou

To the Fune

completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD Amit 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 20620 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June Physician/ 2012 09:39 A M Donna Lee Stewart Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13139 Larchdale Rd, Apt Prince Georges Laurel 5. Social Security Number 6. Sex If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Hours **Director** 1 □ M 2 🎗 F 227-96-6469 54 June 9 1958 Usual Residence of Dece Pennsylvania 28a-f show 10b. County 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD Prince Georges Laurel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13139 Larchdale Road, Apt 3 20708 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify If Yes, Give Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene.
27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) <u>Administrative Assistant</u> Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Edwards Dora Mae Strothers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath a Important: If item 27 is any injury or other tra Derrick Stewart / husband 13139 Larchdale Rd, Apt 3, Laurel, MD 20708 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🕅 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) West Arundel Crem. 06/26/2012 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home, P.A. Signature of F2 al Service Zicensee M01581 313 Talbott Ave, Laurel MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Breast cancer vears Medical Due to (or as a consequence of) **Examiner** Lung metastasis Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ģ in the past 12 monti 1 ☐ Yes 2 X No months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 X 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? 2 🗶 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? Hospital: Other: မ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D45014 06/25/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Isabella Martire, M.D. 8343 Cherry Lane, Laurel, MD 20707

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

IUN 28 2012

21215-0036

Maryland

Baltimore,

Box (

P.O.

Records,

of Vital

Division

32. Registrar's Signatur.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Stephanie Stracke SOPN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor CAre Dulaney Towson Baltimore Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Min (Month, Day, Year) 217-38-5607 **Director** 1 🗆 M 2 🗶 F 69 )ct 3, 1942 Maryland Usual Residence of Deced show 10a. State 10c, City, Town or Location 10d. Inside City Limits notified at Director 28a-f MD 1 Yes 2 No Baltimore Dunda1k r must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Center Place 21222 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Was Decedon. \_ Armed Forces? ¹ ☐ Yes 2 X No Examiner Black, White, etc. þ ō 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. white 3 Widowed 4 Divorced "natural" Completed Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturany or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) clerical Goodwill Inds Be 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) မ Iva Elona Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7712 Iverhill Road Glen Burnie, MD Fay Keen/sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) 21. Signatur, of Funeral Service Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ MON disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine igned by the attending physician and be detached for use as the burial-tran Due to a consequence of) resulting in death) Last Physician/Medical Division of Vitál Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Certificate: To Be 1 ☐ Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 5 Pending within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu 2 🗌 No Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Cortifying Nurse Practitioner To the best of my knowledge, desti diet the time idate and plans, and due to the 29b. Sign 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marguret Corwan CRNP 1869S Parkton, MD 21120 18695 middletown Rd. 31. Date file onth, Day, Year) State JUN 28 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20622 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2312 Mary E. Spence 2012 Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Eastun albet Memorial 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Nov 18, 1929 **Funeral** 9. Birthplace (State or Foreign Months Days 1 M 2 TF Hours **Director** 228-32-7545 Yrs Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2🔻 No MD Dorchester 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21613 701 Race Street #326 USA tems death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 72 hours after o, <u></u> 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify white "natural" Completed 3 ₩ Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 nurse healthcare Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Page 1 and 2 should be Charles Dennis George Sr CAtherine Dorothy Oakley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Christy DeCarlo/granddaughter 6525 Pine Top Road Hurlock, MD 21613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 N Donation 5 Other (Specify) Signatue Funeral Service Ronald State Anatomy Board 655 W. Baltimore Street lage altimore. MD 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, others failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury iner Due to (or as a consequence of): Exami the burial-trar the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 3 in the past 12 months? Day Pregnant at time of death Month Year 1 Yes 2 No detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has After this certificate performe death? performed? Yes 2 No 2 🗌 No 1 Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗀 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending work Accident Suicide M 1 Yes 2 No Investigation

To the Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours within 2 To the i

Registrar

State

Medical

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2

Registrar's Signature

Marke

JUN 28 2012

4 Homicide

29a. Certifier

(Check

only one

31. Date filed (Month

29b. Signature and title

3

AUL W.

Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c License number

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Walter Richard Schulze, Sr. 1:30p 06/26/2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bo BrookLyn Park 4c. County of Death **Examiner** 15 Cedar Hill Rd. Anne Arundel Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F 219-32-5610 Days Hours 05/22/1935 Country) 77 MD Director Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location Brooklyn Park 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10d, Inside City Limits Director Anne Arundel MD 1 Yes 2XXNo 10f. Zip Code 21225 10e, Street and Number 10g. Citizen of What Country? Funeral 15 Cedar Hill Rd. USA death 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify. If Yes, Give 1957 Year or Dates. Specify: 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natun any njury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Produce Produce Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles SChulze (Unknown) Bulla 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 W. 11th Ave., Brooklyn Park, MD 21225 19a. Informant's Name/Relationship (Type, Print) Joann Grimes / Daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) W. Arundel Crematory 06/28/2012 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bailey Funeral Home and Cremation Svc., 21. Signature of Funeral Service Lin M01452 Annapolis Rd., Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau e terval Between Onset and Death Enysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mor Pregnant at time of death 5 Other (specify) 1 Yes 2 G Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of mo Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar **IIIN 28** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Benjamin Santos 1:53 DM 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death N/A General Marylanc Hospital 14more 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Unde Birthplace (State or Foreign Country) Funeral 8. Date of Birth 1 **X**M 2 □ F Min. Days 50 0372071962 216-84-7152 **Director** MD Usual Residence of Decedent 28a-f shov 10b. County the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d, Inside City Limits Director N/A MD ¹X Yes 2 ☐ No Baltimore 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a Windsor Garden Lane Aptc327 21207 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Eve Armed Forces? 1 Yes 2 XIO Black, White, etc. 1 X Never Married 2 ☐ Married "natural", or þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th Grade Disability N/A and Mental Hygie is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stanley Santos Sarah Galloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21207 Department of Health ar Important: If item 27 is any injury or other Joann Santos(sister) 2121 Windsor Garden La. Apt C327, Balto., MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2XX Cremation 3 🗀 Removal from State on-site Crematory Baltimore, MD ☐ Donation 5 ☐ Other (Specify) ignature of Juneral Service Licensee 30sephodus Brown 2140 N. Fulton Jr. Frave., Funeral PA MD Home Baltimore, 21217 2 a. Pa . I. Enter the disease, or comations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ause on each line. Immediate Cause (Final BIL Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Diseas Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed Sepsis andtran that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending philor use as the IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2: autopsy 2 No 1 Tes 1 Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 Mpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month. Dav. Year) 89610 Vumam, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) General

Registrar DHMH 17 Rev 7/2009 Rama

Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JUNE SHIPPENBERG-STEIN 2012 11:02 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min. Hours Director 042-58-3162 1 □ M 2 🛣 F 55 03/15/1957 NY Usual Residence of Decedent 28a-f show 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD N/A 1 X Yes 2 No BALTIMORE , JO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2 BOUTON GREEN COURT 21210 items death \ Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Race - American Indian. Armed Forces? Black White, etc. "natural", or Completed by 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 XNo Specify: If Yes, Give 3 ☐ Widowed 4 X Divorced Year or Dates. WHITE event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. BIO-MEDICAL SCIENTIST MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 STANLEY SHIPPENBERG TRUDI EINHORN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau ALEXANDRA STEIN/DAUGHTER 1200 N. HERENDON ST, #247, ARLINGTON, VA 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 [X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CREMATION INC: 06/28/2012 HAMPSTEAD, MD 21. Signature of Funeral Service Licens e 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ -SME/ Non disease or condition Morita Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) if any leading to immediate cause. Enter Underlying Cause (Disease or injury Exami or Attending Physician: The law requires that the death certificate be executed and the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 19 plonths?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year detached Unknown 9 Unknow ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? Yes 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 Yes 2 No Other: 10 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending fter death. 1 Tes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a To the Funeral Completely filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one ess of person who completed cause of death (Item 23a) (Type, Print) 6701 State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registral Certificate of Death 2. Date of Death 3. Time of Death IIIIIIIDay Physician/ 2012 1:05 PM JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 6300 RED CEDAR PLACE, UNIT #100 BALTIMORE N/ASocial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min Yrs **Director** 212-30-5070 81 MD Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Examiner must be Funeral items 23a 6300 RED CEDAR PLACE, UNIT #100 21209 permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ō þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: 3 Widowed 4 Divorced Completed WHITE event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) BALTIMORE CITY is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATOR/PRINCIPAL PUBLIC SCHOOLS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, and Mental ပ PAUL В SMITH KATE ROSENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra GERALDINE SMITH/WIFE 6300 RED CEDAR PL, UNIT #100, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State netery, crematory or other place)
R ZION TIFERETH
RAEL CEMETERY 4 Donation 5 Other (Specify) 06/26/2012 BALTIMORE, MD Sign ture Funeral Service Lice SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a conse Examiner Sequentially list conditions. if any, leauring to immediate cause. Enter Underlying Cause (Disease or linjury Examine use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 4 Pregnant a 9 Unknown ed by the a 1 ☐ Yes 2 ☐ Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has l lirector, page 2 s autopsy Yes Be ( 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 2 🗆 🗀 Other: မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 24 hours after deal Funeral Director: 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated destributions. The control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Court Rd. Baltimon,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Ronald Francis Travers, Sr. 4:27 P. M 2012 June Medical 4a. Facility Name (if not institution, give street and number)
St. Thomas More Nursing and 4c. County of Death 4b. City, Town, or Location of Death Examiner **Hyattsville** Prince Georges <u>Rehabilitation Center</u> 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Washington, D. C. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 1 **X** M 2 □ F Months Days Hours Min. 579-54-2100 69 Director Usual Residence of Decedent 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits at Director r 28a-f sl notified 1 ▼ Yes 2 No District of Columbia Washington 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ural", or items 23a o Funeral 20020 2639 Naylor Road, S.E.; Apt. 203 United States hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian rmed Forces?

X Yes 2 \( \square\$ No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural" 3 Widowed 4 Divorced **Black** Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Greater Southeast than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12th grade Environmental Service Worker Community Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Catherine Cecelia permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Frederick George **Travers** 19a. Informant's Name/Relationship (Type, Print)
Annie Elizabeth Anderson Travers (Wife)
Ronald Francis Travers, Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904

Ronald Francis Travers, Jr. (Son)

14116 Castle Blvd.; Apt. 102; Silver Spring, Maryland Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) July 6,2012 4 ☐ Donation 5 ☐ Other (Specify) Quantico, Virginia Quantico National Cemetery Signatu e Funeral 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street,N.W.;Washington,D.C.20011 M01421 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Herosulevolt archievascular disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury -trar that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō 5 Other (specify) Month Day Year Pregnant at time of death the ; 9 Unknown ģ Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed Completed by signt be c 1 Yes 2 No 3 Probably 4 Unknown dealites were 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy 2 No certificate 1 Yes 25. Was case referred to medical Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner?
1 \sum Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 5 Pending iniury 1 Natural 24 hours after death Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 — Homicide determined City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one 29b. Signature and title of confine 29d. Date signed (Month. Day, Year) 00636 18 6 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ajit Kurup; M.D.; 4922 LaSalle Road; Hyattsville, Maryland 20782 31. Date filed (Month, Day, Year) gistrar's Signatur

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0709 AM Paul John Triplett, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner**  Birthplace (State or Foreign Country) If Under 24 Hrs. Age (In vrs. last birthday) If Under Date of Birth **Funeral** Social Security Number 214–50–8173 (Month, Day, Year) Months **Director** 65 1 XM 2 □ F Maryland 6/17/1947 ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Baltimore MD Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3.2 should be filed within 72 nours ... sath and Mental Hygiene. at 27 is marked other than "natural", or items 23s m 27 is marked other than "natural", or items 23s ... setc. event, the Medical Examiner must 172 Cherrydale Road 21228 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Sheriff Office Deputy 12 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Paul J. Triplett Pauline Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other transonce Carolyn A. Triplett / Spouse 172 Cherrydale Road, Catonsville, Maryland 21228 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 6/29/2012 Lakeview Mem. Park Sykesville, Maryland Donation 5 Other (Specify) ature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician. disease or condition 45 min Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami physician and s the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Ponknown 1 Tes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy Yes 2 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 1 🗆 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Matural Natural 5 Pending iniury work: 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practitioner: To the cout of my monledge death occurred at the time, date and place, and due to the nature (s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Homes Hospital 900 Balthore MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 28 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:41 PM Physician/ Month TUNA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner HA12BOR MEDSTAR HOS BALTIMORE N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Hours 214 14 2704 **Director** 1 🗆 M 2 🕱 F 90 Maryland 01/09/1922 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 3439 - 6th Street 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 Never Married 2 X Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes. Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 5th College (1-4 or 5+) Sewing Machine Operator Necktie Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Andrew Olup Anna (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Teal / Husband 3439 - 6th Street Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MD State Veteran Cem. 06/27/2012 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland Signature of Fune al Service I/C 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Esquentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) Yes 1 Yes 2 L 9 Unknown Unknown မ Certificate: after death

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Part II. Other significant conditions of	23e. Did tobacco use contribute to the cause of death?  1  Yes 2  No 3  Probably 4  Unknown	
		24a. Was an autopsy performed?  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)  1 \( \sum \text{Yes} \) 2 \( \sum \text{No} \)
25. Was case referred to medical	26. Place of Death (C	heck only one)
examiner? 1  Yes 2 No	Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursin	g Home 5 Residence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 24 hours aft

To the Funeral Dir

completely filled in Medical (Check

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

2012

Name and address of person who completed cause of death (Item 23a) (Type, Print)

BALTIMORE, MD 21225 +KNOVER DENNISTERMULO

State Registrar

29a. Certifier

HOSPITAL

2-04784 tichard Joseph Te			ease Typ Sta	e or ate o	<b>Print in</b> of Maryla	nd / De	epartr	elible Ir ment of icate of	Heal	lth an	e All ( d Mer	Copies ntal Hy	<b>Are L</b> giene	.egib	ole.	201	2 2063
	F	tenistrar					Jerun	cate or	Deal	111		<del></del>	2. Date of [	Reg. N	No.	C 0 1	
Physiciar Adical Examin	er	n. Decedent's Nam Richar	d Jose	eph							1		Month June 2	Da	2	Year	3. Time of Death 1719 hrs
		4a. Facility Name ( Atlantic Ger							Berli	n	Location				Wic	omico	
Funeral Director		5. Social Security N 206-70	-1987	6. Sex	и 2 <u>Г</u> F	7. Age (In y		oirthday) Yrs	Month	hs Day		er 24Hrs. s Min.	8. Date o			Forei	rthplace (State or gn gn puntry)PA
land f show any once.	ſ	PA	10b. County Buc	ks			-	own or Location Lkertown									10d. Inside City Limits 1 Yes No
n the Mary 3a or 28a	2	725 W								951	_					of What Cou	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other transmatic event, the Medical Examiner must be notified at one.	rune	11. Marital Status  1 Never Marri  3 Widowed		orced I	12. Was Deco Armed Fo 1 Yes Yes, Give Year	orces?			es, spec	ify Cubar		n, Puerto F	ecify Yes or Rican, etc.)	No-		Race - Amer White, etc. ecify: Whi	ican Indian, 8lack,
72 hours a "natura" al Examin	Completed by	15. Decedent's Elementary/Sec			or Dates: highest grad College (1			_	ost of wo	orking life		kind of wo				of Business	
O36	림	12						disal	этес								
15-003 filed withii Hygiene. 4 other th	3[	17. Father's Name											First, Midd		den Sur	name)	
D 21215-0036 should be filed within 7 and Montal Hygiens is marked other than natic event, the Medica	8	Ronald						19h Mailin	Addres			_	Sma ural Route		. City o	or Town, State	e. Zip Code)
Shou and N	_[	Gretch	en M.	,				725 Te of Dispos	√ Bı	road	St	#2	Quak	ert	own	ı PA ´	1 8 9 5 1 r Town, State
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury or other traur		1 Burial 2	Cremation Other S		Removal fro			anti	ner place C C1	ena rema	tor		28/2	012	G1	len Bi	urnie MP
Balti permit. Departm Importa	4	21. Signature of Fu	MI		_												rvice 21061
Physician /Medical		23a. Part f. Enter ti failure. List or	he disease, or nly one cause	complic on eac	cations that ca h line.	aused the d	leath. Do	not enter t	ne mode	of dying,	such as	cardiac or	respiratory	arrest,	snock,	or near	Approximate Interval Between Onset and Death
Examiner		Immediate Cause or condition resulti			ardion ue to (or as a												
	<u>i</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause c.															
	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.															
be exect by a sician are urial - tr	Gal	X UNPENDED	)		AMENDED 2	23a,27	7, pe	r me,	3930	8-9	-12 :	sm.					
Box 68760, to death certificate be the attending physici and for use as the burnied for use		IF FEMALE: 23b. Was decedent past 12 month 1 Yes 2	s?		23c. If yes, of the live by 4 Pregnt	oirth ant at time		2 Fe	tal death		Ectop	oic pregnar	ncy	_		ate of delive	ry Day Year
D.O. E. that the detached	b P	Part II. Other sign	ificant condit	ions	contributing to	death but	not resu	Iting in the u	underlyin	ng cause	given in F	Part I.					o the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the burial -	Completed												p	Vas an utopsy erforme es 2			outopsy findings available completion of cause of
al R	Be C	25. Was case refe	rred to medica	-					-20	26.Place		n (Check o					
Vita bysici this c		examiner? 1 <b>V</b> Yes	2 No	Ho				VOutpatient		DOA			Home 5		sidence		er:
on of ading Plan. After the funera		27. Manner of Dea	th 5 Pen	ding	28a. Date (Month	of Injury , Day,Year)	28	Bb. Time of I	njury		ıryatWo Yes 2	_	28d, Desci	ibe how	/ injury	occurred	
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1	Certification:	2 Accident 3 Suicide 4 Homicide	6 Cou	stigation Id not b rmined	28e Plac		At home	e, farm, stre	et, factor	ry, office	building, (	etc.		on (Stre		Number or R	tural Route Number, City
the Hospi hin 24 hou the Funei npletely fil	Medical C	29a. Certifier 1 (Check only one) 2	_	miner:	n: To the bes	of examinat	wledge, tion and/	death occu or investiga	rred at th	ne time, d ny opinio	late and p	lace, and	due to the	cause(s date and	and m	nanner as sta , and due to t	ated. the cause(s)
To wit	Me	29b. Signature and	d title of certific		and manner s	Destated			29	9c. Licen	se numbe	er	_	2	9d. Dat	te signed (M	onth, Day, Year)
		Tho	low 1	10	King	JA.	Utom 22	c.D.		O.C.	M.E.	001	VIĒ	J	June 2	26, 2012	
$\emptyset$		36. Name and add Theodore						aminer	900 V	/. Baltir	more S	treet, Ba	altimore	MD 2	21223		
Sta Registi		31. Date filed (Mo.	nth, Day, Year) 2012	S.	32. Re	egi rar's Si											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HATTIE TENNESSEE 4205 A M 20/2 lun Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplac Country) VA 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours 03/21/1933 224-38-8152 Director 1 □ M 2 🖾 F 79 Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No BALTIMORE RANDALLSTOWN 10e. Street and Number 10g. Citizen of What Country? Funeral 9707 LIBERTY ROAD 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces? Black, White, etc. Ne Tennessee 1 X Never Married 2 ☐ Married Completed by 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SCHOOL TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ROBERT TENNESSEE MARY BYNUM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORETTA TENNESSEE/DAUGHTER 140 DONIZETTI PLACE APT. BRONX, NY 10475 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7/6/2012 PLEASANT GROVE BAPT. SOUTHHAMPTON, VA 22. Name and Address of Facility JAMES A. MORTON & SONS Signature of Funeral Service Licensee annes a. 1701 LAURENS ST., BALTO., MD 21217 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Subarachnoid hemorrhage Physician/ disease or condition resulting in death) days Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): ed by the attending physician and detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by I completely filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Artery disease 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Sp'CC ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 **Ecrtifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 7033 Jun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Belvedere Ave, Balimore, M D21215 Zhon 31. Date filed (Month, Day, Year) 22. Registrar's Signature State racked JUN 28 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Physician/ Jerry Thomas 2012 10.30 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4711 Berwyn House Road College Park Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min (Month, Day, Year) Hours 215-58-8664 1 X M 2 □ F Director Feb 28, 1949 63 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at Completed by Funeral Director 28a-f 1 Yes 2X No MD Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be 23a 20740 4711 Berwyn House Road USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ori 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Specify: "natural", 3 Widowed 4 Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical | 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) disabled none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk and Mental ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Davis/friend 6913 Dartmouth Avenue College Park, MD 20740 Health tem 27 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important; If ite any injury or oth ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
☐ Donation 5 ⚠ Other (Specify) in State 4 ☐ Donation 5 🛣 Other (Specify) f Funeral) . Name and Address of Facilit Funeral) ervice Licensee R-nald S State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter or heart failure. List only one cause on Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ LOSOSC en Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No ę Pregnant at time of death the 9 Unknown Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 1 Yes 2 No 1 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at s after death. I Director: After t Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No (Month, Day, Year) 5 Pending 1 Natural Accident Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State)

Registrar DHMH 17 Rev 06-2011

State

within 24 hours a

To the Funeral I

completely filled

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

ou

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, amend #5,9,12,15,16a&b,17,18 &19a&b Per ANA BD G929 7/13/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0012 RM HAROLD THOMAS 6 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death CIROSS SILVER HOSPI SPRING MONTGOMERY TAI Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 327-52-6310 Mississippiunk 1 MM 2 □ F Director Jan 10, 1935 Usual Residence of Decedent 28a-f show an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MONTGO MERY SILVER 1 Yes 2 No SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's 20901 1000 DALEVIEW SA Armed Forces? 1952—
1 X X es 2 No 1957
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify Completed 3 Widowed 4 Divorced WHI 8 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 salth and Mental Hygiene. 127 is marked other than "r traumatic event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) -unk Carpenter Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <del>unk</del> ပ John Robert Thomas Sarah Baker 19a Informant's Name Relationship (Type, Print)
Michael Beguzman case worker 12 Ammed Aforces a Retterement of Homes 3700N. Capatol St N.W. ge 1 and 2 s nt of Health a : If item 27 i 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 💢 Other (Specify) in state Licenses Signat Funeral S. rv'c 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Virector . 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death RIGOMUSUR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** PAILURE SPIRATORY Sequentially list conditions, Examiner cause. (Disease or injury (or as a consequence of): EPSIS Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a HI Physician/Medical Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year 1 | Yes 2L 9 | Unknown the 9 Unknown signed by t d be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by FIBRILATION 1 Yes 2 No 3 Probably 4 Unknown Completed MYELDDYSPLASTIC SYNDROME 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 performed 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ျှ 1 Minpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man r of Death within 24 hours after deau..

To the Funeral Director: After th 28a. Date of injury (Month, Day, Year) 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation
6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Almandundo 53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar MD. 9801 GEORGIA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 4a. Facility Name (If not Institution, give street and number, une /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year Mar 15, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Months Days 215-60-2226 Mary Land 57 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 obcoming any injury or other traumatic event, the Medical Event. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County MD No Yes 2 □ No Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 2821 Ashland Avenue 21205 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: 1 X Never Married 2 Married 1 ☐ Yes 2 No Specify black Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) medical technician healthcare Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Simon Truitt Lucinda Stewart 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cynthia TRuitt-Paige/sister 2821 Ashland Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 X Other (Specify) in state 21. Sign tune of Funeral Service Romand S. Hade, 22. Name and Address of Facility State Anatomy Board 655 W, Baltimore Street Director 21201 Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Enter the disease, or complications that causes a shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Pregnant at time of death 5 Other (specify) signed by the att 2 No 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has page ; 2 No 2 🗌 No 1 Yes 1 Tes certificate or Attending Physician: I director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home Hospital: 3 🗆 DOA 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 No 1 X Inpatient ဂ္ this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: hours after death. Injury 5 Pending investigation 1 🔀 Natural М 1 ☐ Yes 2 ☐ No 2 Accident by the 1 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 - Homicide filled in

State Registrar

completely

29a. Certifier

30. Name and

(check only one)

29b. Signature and tille of cortifier

Medical

To the Hospital within 24 hours To the Funeral

> NWE MI ZIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 28 2012

address of person who completed cause of death (Item 23a) (Type, Print)

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES

29c. License number

-000

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

16,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ - Month Year 1245 PM Tune chae Wa KOV 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 215-70-0714 Director 1 🕱 M 2 🗆 F 11/28/1956 Maryland 55 items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 501 E. Preston St. Apt 426 21202 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner 1 ☐ Never Married 2 🙀 Married "natural", or þ 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Black Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 hand Mental Hygiene. 77 is marked other than "r College (1-4 or 5+) Elementary/Secondary (0-12) Self Employed 10th Grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lacy Walker Helen Coker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 810 Northrop Lane, Middle River 21220 Romaine Walker(wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) on-site Crematory Baltimore, MD Signature of Funeral Service | censes Joseph Ad Hes of Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Interval Between mmediate Cause (Final Onset and Death Physician/ Gastrointestinal disease or condition resulting in death) WEEKS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or injury the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical death certificate be P.O. Box 68760 as 1 ise s 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown ρ Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Hepatitis C. VINUS, Climbosis Division of Vital Records, 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed death? 2 X No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be after death Director: / 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number determined City or Town, State) within 24 hours a

To the Funeral I

completely filled To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00 8284538 30. Name and address of person who domedeted cause of death (Item 23a) (Type, Print) niversity of Maryland Medical Center 22 South Greene Street Baltimore, glay and Hobbs

State Registrar 2126

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ IUne Medical City, Town, or Location of Death County of Death **Examiner** Age (In yrs. last birthday 8. Date of Birth **Funeral** 1 M 2 N F Months Min Country) 0471071919 93 VA Director 219-36-1244 Usual Residence of Decedent show ms 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Sykesville Carroll 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10q. Citizen of What Country? Funeral USA 21784 710 Obrecht Road permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housekeeping Housekeeper 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Florence Etta Dodge George Popkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5841 Mineral Hill Rd. Sykesville, Md 21784 Stanley Nusbaum-grandson 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) South Carroll Crem 6/28/12 Winfield 22. Name and Address of Facility Fletcher Funeral Home, P. A lice Licensee 21157 254 Main St., Westminster, MD Ε. he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Par 1. Enter Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Ca se (Final disease ar candition Physician/ disease ar condition resulting in death) Medical Due to (or as a consequent e of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the hurial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant 9 Unknown Month Other (specify) Pregnant at time of death the s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 perform 1 Yes 2 No certificate Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) funeral director. examiner? 2 Z No Hospital: မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 5 Pending Natural 24 hours after death. Funeral Director: A 2 Accident Investigation filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🔀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signatore and title of certifie

2

who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 20637 1. For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day June 22, 2012 Modical Examiner 1815 hrs Whiting Calvin 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bon Secours Hospital Baltimore 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) **Funeral** Foreign Country) Min Months Davs Hours 01 - 28 - 64Director 215-78-8697 48 1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits 1 X Yes 2 No 1 23a or 28a-f show notified at once, Baltimore NA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1510 N. Mosher Street 21217 **USA** Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. 11. Marital Status or items White, etc. African If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes 4 Divorced If Yes, Give Year 1 Yes 2 No specify: specify: American ₹ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hou sarment of Health and Mental Hygienc.
portant: I tiese 27 is marked other than "nat ury or other fraumatic event, the Medical Exa College (1-4 or 5+) NA Elementary/Secondary (0-12) 12th Grade Dept. Social Services Computers 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin J. Whiting, Mildred Bover 19a. Informant's Name/Relationship (Type, Print ) Mot er 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred Whiting Goolesby 1510 W. Mosher Street Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06-30-12 Arbutus Mem. Park Arbutus, MD 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and Medical Death a Narcotic (morphine) Intoxication Immediate Cause (Final disease **Æxaminer** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of). if any, leading to immediate Examiner nause. Enter Underlying Geuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and AMENDED 23a,pt.II,27,28a-f,per me,g930 8-2/-12 sm Physician/Medical X UNPENDED the attending physician red for use as the burial -The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death Day Live birth 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Hypertensive Atherosclerotic Cardiovascular Disease; Completed this certificate has been a 24a. Was an 24b, Were autopsy findings available Chronic Obstructive Pulmonary Disease autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes ctor, 25. Was case referred to medical 26.Place of Death (Check only one) Be Other Nursing Home 5 Residence 6 Other Hospital: 1 ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 Natural subject took drugs 1 Yes 2X No 5 Pending fd 6-20-12 fd 6:00 am 2 X Accident 6 Could not be Suicide

Hospital or Atteoding Physician: Director: d in by the f e Funeral

cal

28e. Place of Injury - At home, farm, street, factory, office building, etc.

(Specify) found in multi-family apartment (Specify) found (Specify) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 25, 2012 O.C.M.E.

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

31. Date filed (Month, Day, Year) State JUN 2 8 2012 Registra

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Richard B. Yeagley June 2012PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 301 Surrey Court Fallston Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days 215-30-4896 **Director** 1 🛛 M 2 🗆 F 78 Yrs Nov 19, 1933 Maryland 28a-f show aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified MD Harford Fallston 1X Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 301 Surrey Court 21047 USA items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ♣ Yes 2 □ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 9 ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 154-56 Specify "natural", 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rany injury or other traumatic percent." than, Elementary/Secondary (0-12) College (1-4 or 5+) 12 0 salesman automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Clifford Martin Yeagley Marie Elizabeth Detlof 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Snyder/daughter 301 Surrey Court Fallston, MD 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22. Name and Address of Facilit State Anatomy Baltimore, MD Sign Board 655 W. Baltimore Street Director 23a. Partyl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ C Cancel disease or condition resulting in death) Medical Due to (or as a co-seq ence of): Examiner Sequentially list conditions, if any local sequentially cause. Enter Underlying Cause (Disease or injury Examine Due to or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) Day g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes ပ္ ER/Outpatient 3 DOA 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending Accident M 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) etely filled in by determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registra

(Check

only one)

29b. Signature and title

Ashkan Bahrani

31. Date filed (Month, Day, Year)

 Registrar's Signature JUN 28 2012

30. Name and agdress of person who completed cause of death (Item 23a) (Type, Print)

9114 Philadelphia Road Baltimore, MD 21237

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

20

20/2

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	tate of Maryland				Mental Hyg	giene	2 20020
			Registrar  1. Decedent's Name (First, Middle, Last)		Cen	tificate of De	eath	2. Date of Dea	Reg. No. 4	2 2000:
	Physicia		Louise Up	March				Month	25 201	3. Time of Death A
	Medic Examin		4a. Facility Name (if not institution, give street 400 Millington Av		107	4b. City, Town, or Lo			4c. County of Dea	ath
	Funeral		5. Social Security Number 6. Sex 1 □ M	7. Age (In yrs Jas	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	g. B (Year) C	rthplace (State or Foreign
	Director		Usual Residence of Decedent	- n	Yrs.			111-4-1	928	NY
	land show	tor	10a. State 10b. County	10c. City,	Town or Loc					10d. Inside City Limits
	e Mary 28a-	Jirec	MD 10e. Street and Number			Baltimo	ore			X☐ Yes 2☐ No
	filed within 72 hours after death with the Maryland al Hygiene d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Funeral Director	400 Millington A	venue Apt	107	10f. Zip Code	223		10g. Citizen of What C	ountry?
	items	Fun		Vas Decedent Ever in U.S.	13. W	as Decedent of Hisp Yes, specify Cuban,	anic Origin? (Sp Mexican, Puerto	pecify Yes or No-	14. Race - Am	
36	after or xamir	d by	1 Never Married 2 Married	Yes 2 X No Yes, Give Year or Dates.		Yes 2 No		, , , , , , , , , ,	Black, Whi	
9	hours natura dical E	olete	15. Decedent's Educati	on	16a. Decede	ent's Usual Occupati	on	liin.	16b. Kind of Business	s Industry
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0 0	Hygie Other ent, th	Be C	12 17. Father's Name (First, Middle, Last)				8. Mother's Nar	ne (First, Middle, I	Maiden Surname) <b>U</b>	NK
ylan	d be fi Mental arked atic ev	2								
, Mar	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, P Bridgette Bulloc		19b. Mailing 2315	g Address (Street and Lawnwoo	d Number or Ru d Circ	ral Route Number, le Gwyl	City or Town, State, Z	ip Code) 0 21207
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State cer	netery, crem	ition (Name of atory or other place) Crematio		Date 7-2012	20c. Location - City of Hanover	
Baltı	permit. Page Department ( Important: If any injury or		21. Signature of Funeral Service Licensee	ntre	22.	Name and Address	of Facility Ph	illip A	Weather Baltimore	ford FS PA MD 21213
П			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause	ons that caused the death.						Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	corono	214	artery	disca	(1		Onset and Death
	Examiner		Toodking in douting	Due to (or as a consequent	nce of)	, )	ST#70 SS	_		Gene
Α.	n #	iner	Sequentially list conditions, b. — if any, reading to immediate cause. Enter Underlying	bue to (or as a conseque	nce of):					700,7
D	ecuted and Il-trans	dical Examine	Cause (Disease or iinjury that initiated events c. — resulting in death) Last	Due to (or as a conseque	nce of):					
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9/89	rtificat ing ph e as th	/Mec	IF FEMALE:							
Box 6	ath ce attend for use	Physician/Me	in the past 12 months?	yes, outcome of pregnand Live Birth 2  Fetal o Pregnant at time of dea	death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of d Month	elivery Day Year
O.	the de by the ached	hysi		Unknown						
д.	es that igned be det	by	Part II. Other significant conditions contribu	iting to death but not result	ting in the ur	derlying cause given	in Part I.		bacco use contribute t ′es 2 □ No 3 □ I	o the cause of death?  Probably 4 🗆 Unknown
Records,	require been s should	leted	-COF1/					24a. Was a		utopsy findings available
ပ္သ	he law te has age 2 s	Completed						autop	sy prior to med? death?	completion of cause of
<u>e</u>	ian: Ti ertifical ctor, pa	Be C	25. Was case referred to medical examiner?			26. Place	e of Death (Chec	1  Yes	2 KINO I LI YE	s 2 No
Vita	Physic this ce al dire	မ	1 Ves 2 No	1 ☐ Inpatient 2 ☐ El	R/Outpatient 8b. Time of				ence 6 Other (Spe	cify)
0 0	nding F tth. : After e funer	cate	1 Natural 5 Pending 2 Accident Investigation	Ba. Date of injury (Month, Day, Year)	injury	28c. Injury at work? M 1 1 Ye	t s 2 □ No	28d. Describe ho	ow injury occurred	
Division of	l or Atter after des Director	Certificate:	3 Suicide 6 Could not be	Be. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St City or Town	treet and Number or Ro n, State)	ıral Route Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical		To the best of my knowled in the basis of examination a	ind/or investi	gation, in my opinion,	death occurred a	at the time, date an	nd place, and due to the	cause(s) and manner stated.
	To th withir To the comp	Σ	29b. Signature no title of certifier	ude un	JJago, di	29c. License no			29d. Date signed/Mon	
	\		30. Name and address of person who comple	ted cause of death (Item 2	3a) (Type, Pr	int)	10/		10/12	
	\		APTIME SHROEDER MI	House PHKI	CIANS	705 Da	TAU	RIVE L	MARLANT	M) 4090
	Stat Registra	e ir	31. Date filed (Month, Day, Year) JUN 28 2012	32. Registrar's Synatur	Barka					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 26 26 2012 Leonard Neilson Ziegler 12:35 a M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cockeysville Broadmead If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, June 12 5. Social Security Number 9. Birthplace (State or Foreign 1 M 2 □ F **Funeral** Country) MD Months 1915 Director 97 June 212-28-3934 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Cockeysville MD Baltimore 10f, Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 21030 13801 York Rd. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White, etc. ğ 1X Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify. white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maritime Seaman 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Elizabeth Clausen Leonard Peterson Ziegler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14600 Western Road, Sparks, MD 21152 Ophelia Hollingshead/friend 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Meadowridge Memorial Park 6/28/12 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD Sign ure 22. Name and Address of Facility emmon Funeral Home of Dulaney Valley, Inc. O W. Padonia Rd., Timonium, MD 21093 23a. Part 1. Enter the lisease, or complications that cau shock, or heart ailure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician. Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician a the for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No g Unknown this certificate has been signed by the raid director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖗 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 🕏 No Yes Be ( funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After the letted filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Natural Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical 👺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 101 completed cause of death (Item 23a) (Type, Print) ame and address of person ZARO 32. Registra's Signatura State Registrar

136/130

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Month 2012 11:35 P M Richard Morris Abell, Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral Director** 579-40-4682 1 **X** M 2 □ F 85 January 16, 1927 Maryland Usual Residence of Decede 28a-f show 10c. City, Town or Location with the Maryland 10a State 10b. Count 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Charlotte hall 10e, Street and Numbe ö 10g. Citizen of What Country? ms 23a or must be r Funeral 29449 Charlotte Hall Road 20622 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 No U.S.
If Yes, Give
Year or Dates. Armv by 1 Never Married 2 Married an "natural", or Medical Examir filed within 72 hours after land 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Al Hygiene.
Ad other the Elementary/Secondary (0-12) 12th. College (1-4 or 5+) Self Employed Lock Smith Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be file ental 2 Edith Morris Frank T. Abell t. Page 1 and 2 should be then to Health and We trant. If item 27 is mark jury or other traumatic Baltimore, Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 740 :: Valley Dr. Waldorf, Maryland 20603 Darryl Abell/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet's Cem. June 14, 2012 Cheltenham, MD. 22. Name and Address of Facility Huntt Funeral Home 21. Signature of Funeral Service License MO1164 3035 Old Washington Road, Waldorf, MD. 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Aspiration Yneumonia. Physician/ resulting in death) Medical Due to (or as a consequence of): Examiner ysphasia. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Parkinsons disease attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Urinory Tract Infection Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown End Stage Dementic 24b. Were autopsy findings availa oprior to completion of cause of death? 24a. Was an Atheroscienotic Cardiovascular disease perform 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner?
1 Yes 2 No Other: 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No nours after death.
neral Director: After the funeral on by the funeral Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29d. Date signed (Month, Day, Year)
6 - 8 - 2012 29b. Signature and title of certifier 29c. License number 50653 vyan -c SUrang. G 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GYAN.

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 0615 M ANNIS BOBBY **EDWARD** 2012 un Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KIROMICO SAU156414 TONIN SULA REGIUNAL Cester MADICAL If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Funeral Hours (Month, Day, Year) NOV.23,1947 Days Min 225-66-9861 Director 64 1**X** M 2 □ F VIRGINIA Show 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has a "Zis marked other than "natural", or Items 23a or 28a-1 shoother tranmatch event, Ite Medical Examiner must be notified at cother tranmatic event, Ite Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Tyes 2X No ACCOMACK BLOXOM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23308 USA 24206 ANNS COVE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION BRICK MASON 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ WILLIE EWELL WALTER ANNIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 LEMMING COURT - VIRGINIA BEACH, VA 23456 PAMELA DUNCAN (DAUGHTER) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any Injury or otl 1 X Burial 2 Cremation 3 Removal from State 6/13/2012 PARKSLEY, VA 4 Donation 5 Other (Specify) PARKSLEY CEMETERY 21. Signature of Funeral Service Lice THORNTON FUNERAL HOME 22. Name and Address of Facility 24183 CHADBOURNE ST. PARKSLEY, CARL U. THORNTON PO BOX 264, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition GUOMOUS Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events the burial-transi Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 SB IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ ate has been signed by the atterpage 2 should be detached for in the past 12 months? Month Day Veal Pregnant at time of death Yes 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 2 NO 2 🗌 No Yes completely filled in by the funeral director, Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral D Medical Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practition To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of o M. D 0 30690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carroll St. 501:55000 MD James RTIN E M. 0 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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			For State	te of Maryland	-	rtment of He tificate of D			2	0.10	20	C 1 C				
			Registrar  1. Decedent's Name (First, Middle, Last)		Cert	ilicate of D	eauri	2. Date of Dea	Reg. No.	414	3. Time of De	eath				
	Physicia Medic		Helen G. Baker	Year	7:00 1											
	Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Vindohona Nursing Home  Braddock Heights  Freder													
The second	Funeral		Vindobona Nursing I 5. Social Security Number   6. Sex	7. Age (In yrs. la:	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birtl	h	9. Birthpla	irthplace (State or Foreign					
	Director		579-30-7607 1 □ M 2	<b>≇</b> F 85	Yrs.	Months Days	Hours Min.	Sept 25	, 1926	Mary]	land					
	and show at	'n	Usual Residence of Decedent  10a. State  10b. County	10c. City	, Town or Loc	ation		I		100	d. Inside City	Limits				
	Maryla 28a-f	Director	Maryland Frederick	Fre	derick						1 Yes 2	! 🗆 No				
	th the	al D	10e. Street and Number 18 N. Wisner Street			10f. Zip Code 21701			10g. Citizen of USA	What Country	V?					
	eath wi	Funeral	11. Marital Status 12. Wa	s Decedent Ever in U.S.	13. W	as Decedent of His	panic Origin? (Spe	ecify Yes or No-		ce - Americar	ı Indian,					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 If Y	ned Forces? ] Yes 2 🛣 No es, Give r or Dates.		Yes, specify Cuban  Yes 2 No	Specify:	Hican, etc.)	Blac Specify	Black, White, etc. cify: white						
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pu	tal Hyg d othe event,	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			e)						
ryla	d Ment marke matic	ř	Lewis Crouse  19a. Informant's Name/Relationship (Type, Prin			a Address (Street ar		A. Mye		Otata 7in Oa	-1-1	- 3				
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ore,	of Hear of Hear Hitem		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Remove		ace of Dispos emetery, crem	sition (Name of atory or other place	)	Date	20c. Location	- City or Tow	n, State					
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?	Live Birth 2 Fetal Pregnant at time of d Unknown		Other (specify)					yay Yea	ar				
P.O.	s that t gned b	by	Part II. Other significant conditions contribution	ng to death but not resu	ulting in the ur	nderlying cause give	en in Part I.		bacco use conf							
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Division of Vital Records,	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e						6							
۵	Hospital of 24 hours a Funeral D etely filled i		29a. Certifier 1 Certifying Physician: T	o the best of my knowle	edge, death o	ccurred at the time.	date and place, a	nd due to the ca	use(s) and man	ner as statec						
	he Hos in 24 h he Fur ipletely	(Cheek 2 Medical Examiner On the basis of examination and/or investigation in my opinion death occurred at the time, date and place, and due to the cause(s) and many										er stated.				
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			30. Name and address of person who complete	ed cause of death (Item	23a) (Type, Pi	rint)	10/9/		JUN		,					
	V		31. Date filed (Month, Day, Year)	SYED  32. Registrar's Signati	E S	301 70	LL Ho	USE,	FRE	DEF	-/cK	MD				
	Sta Registr		JUN 1 3 2012	Sz. Hagistrar's Signati	1. 4	arke										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June June Physician/ 2012 рМ Ethel Adele Bray 3:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Carroll Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days Hours (Month, Day, Year) Min. **Director** 217-09-1273 1 □ M 2 🔀 F 91 07/02/1920 MD or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director Howard Ellicott City 1 Yes 2X No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? and Mental Hygiene. is marked other than "natural", or items 23a Funeral 72 hours after death with 9113 Way Cross Road 21042 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates White injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home of Health and Mental Hygi of Health and Mental Hygi fitem 27 is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Edward Tydings Emma Adele Royston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Vandermer - Daughter 12128 Carroll Mill Court Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State St. John's Cemetery 06/19/2012 4 Donation 5 Other (Specify) Ellicott City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ocard disease or condition Medical resulting in death) Due to (or w a consequence of Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buris Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☒No 9 ☐ Unknown Division of Vital Records, P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed. Yes 2 certificate 2 🗌 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and the o 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month,

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	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		-	-		Date of Death Month	flume 0	3. Time of Death
~	Medic Examin	al	Harold G. Boyer  4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of	J	une	Day 20 4c. County of D	12 8:24 P M
	Examin		519 Bayberry Drive		Seve		_			Arundel
	Funeral Director		5. Social Security Number 219–28–5645  Usual Residence of Decedent  6. Sex 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	Date of Birth (Month, Day, Yo pril 19	ea <i>r)</i> 9,1933 Ma	Birthplace (State or Foreign Country) aryland
	Maryland :8a-f show tified at	rector	10a. State 10b. County 10c. C	City, Town or Loc Severna						10d. Inside City Limits 1 ☐ Yes 2 🎇 No
	s 23a or 2 s ust be no	Funeral Director	10e. Street and Number 519 Bayberry Drive		10f. Zip Code 21146			10	g. Citizen of What <b>USA</b>	Country?
9036	filed within 72 hours after death with the Maryland al Hygiene.  J other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	by	The Never Married 2 I Married 1 Layes 2 I No	OI CUI	Vas Decedent of His f Yes, specify Cubar		in? (Specify , Puerto Rica	Yes or No- an, etc.)		merican Indian, /hite, etc. <b>White</b>
21215-0036	be filed within 72 hours ntal Hygiene. ed other than "natura event, the Medical E:	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	(Give I life. D	dent's Usual Occupa kind of work done di O NOT use retired) Master Ele	uring most		10	6b. Kind of Busine	ess/Industry
Maryland 2	ild be filed w Mental Hygi iarked other atic event, t	To Be	17. Father's Name (First, Middle, Last) Frank Boyer	1 1	ascer hi	18. Mother	r's Name (Fi	rst, Middle, Ma Hurst		
	2 shouth and the subsection of	75	19a. Informant's Name/Relationship (Type, Print)  Cindy May / Daughter		ng Address (Street a Baltimor					, Zip Code) na, MD 21122
Baltimore,	Page nent o ant: If ary or			Place of Dispo cemetery cren en Have	sition (Name of natory or other place N Memoria Park	j J	June 1 20	$[5, \mid c]$	oc. Location - City	
Balt	permit. Page Department Important: I any injury o	li ii	21. Signatury of Funeral Service Incensee	B 4	Name and Address arranco & 95 Ritchi	Sốns e Hwy	s, P.A	. Sever	na Park na Park	Funeral Home , MD 21146
١,	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	et fo	er the mode of dying	g, such as c	cardiac or re	spiratory arrest	,	Approximate Interval Between Onset and Death
	Examiner		Due to (or as a conse	quence of):	u ar	ten	U	dise	ase_	
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence Jij.	1		/			
	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last C. Due to (or as a conse	quence of):						
200	ate be physici the bu	edical	d							
. Box 687	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and real director, page 2 should be detached for use as the burial-transitial director.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnant in the past 12 months? 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3 🗀	Ectopic pregnancy Other (specify)	у	_		23d. Date of Month	delivery Day Year
ls, P.O.	requires that the dea seen signed by the a rould be detached to		Part II. Other significant conditions contributing to death but not r							e to the cause of death?
of Vital Records,	sician: The law requii certificate has been lirector, page 2 should	Completed by	preumonia					24a. Was an autopsy performe	prior deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
ital	ysician: is certific director,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		Othe		h (Check oni			
on of V	nding Phys th. : After this e funeral d	cate: To	2.7 Manner of Death  1 ☐ Inpatient 2 ☐ 28a. Date of injury  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28b. Time of injury	28c. Injury	at	28d.		ce 6 Other (S injury occurred	pecify)
Division	al or Atter s after dea al Director ed in by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec				_	Location (Stre City or Town, S		Rural Route Number,
	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director, After thi completely filled in by the funeral	Medical	29a. Certifier (Check 2 Medical Examiner: On the best of my knot only one) 3 Certifying Nurse Practitioner: To the best of my knot only one) 1 Provided Head of the best of th	ion and/or invest	tigation, in my opinio	n, death occ	curred at the	time, date and	place, and due to t	the cause(s) and manner stated.
	North Con		29b. Signature and title of certifier		29c. License	0-0	7		d. Date signed (M	
			30. Name and address of person who completed cause of death (Its	em 23a) (Type, F	Print)		) (		une 1	0,010
	17067		ERIKA FELLER 22 S. (31. Date filed (Month, Day, Year) 32. Redistrar's Sign			ALT	., M	D 2	1201	
3	Stat Registra		31. Date filed (Month, Day, Year)  JUN 13 2012  32. Redistrar's Sign	iature .	have					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Brendza Frank Dominic 2:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Linthicum Tate Chesapeake Hospice House If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 191-12-6983 Months 88 Director 1**X** M 2 □ F Aug. 17,1923 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Annapolis Anne Arundel MD 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21409 503 Majestic Prince Drive 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian Armed Forces?

1 X Yes 2 \subseteq No 1941—
If Yes, Give Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐XNo Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important. If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Hospital Hospital Administrator 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Elizabeth Sviatko Joseph Brendza 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
503 Majestic Prince Drive Annapolis, MD 21409 19a. Informant's Name/Relationship (Type, Print) Cindy Easton/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 14, 1 NBurial 2 Cremation 3 Removal from State Crownsville, MD MD Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that cause shock, or heart failure. List only one cause on each lin ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physiciani Moville disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician at for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death ed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, No 3 Probably 4 Unknown Completed 1 Yes been sig 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence Other (Specify) Mapper of Derth 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work n 24 hours area on a Function of Function Director: After a Function of the fu 5 Pending 1 Yes Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital M. Glan Burnie, MD. 21061

DHMH 17 Rev 06-2011

State Registrar dhish Markan 305

31. Date filed (Month, Day, Year)

COGGINS SR., TURNER M491318

			Please Type or Print in Black In		
	_		State of Maryland / Den State of Maryland / Den Registra Amended # 23e. perphysician 6 / 26	112/cchd/ba 112/cchd/ba 112/cchd/ba	Reg. No. 2012 20647
ľ	Physicia	_	1. Decedent's Name (First, Middle, Last)  Turner Coggins, Sr.,	2. Date of De Month	eath Day Year 3. Time of Death 10:35 A M
3 mg	Medio Examin	-	4a. Facility Name (if not institution, give street and number)  CIVISTA MEDICAL CENTER	4b. City, Town, or Location of Death	4c. County of Death  CHARLES
	Funeral Director	П	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 245 20 5202 1X M 2 F 87 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Bit Months Days Hours Min. (Month, D. 01 / 14 /	rth 9. Birthplace (State or Foreign country)
No.	3	<u>ا</u>	Usual Residence of Decedent		10d. Inside City Limits
	Maryla 28a-f s notified	Director	MD Charles LaPla		1 🔀 Yes 2 □ No
	s 23a or	Funeral [	10e. Street and Number 8922 Penns Hill Road	10f. Zip Code 20646	10g. Citizen of What Country? USA
920	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	by	1 Never Married 2 Married 1 X Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒ No Specify:	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036		Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working OO NOT use retired)	16b. Kind of Business/Industry Charles County
	e filed within tal Hygiene.	Be Co	Elementary/Secondary (0-12)  College (1-4 or 5+)  Sch  17. Father's Name (First, Middle, Last)	ool Administrator	School System
Maryland	eve eve	To	Luther M. Coggins	18. Mother's Name (First, Middle Agness Small	
	O + 5 +		19a. Informant's Name/Relationship (Type, Print)  Turner Coggins, Jr./ Son   8922	ng Address (Street and Number or Rural Route Numb P. Penns Hill Rd.LaPla	er, City or Town, State, Zip Code) Lta, MD 20646
nore,	- 4 = 5		T Burlar 243 Cremation 3 Hemovarion State	matory or other place)	20c. Location - City or Town, State Elizabeth City, NC
Baltimore,	permit. Page Department Important: any injury o		21 Signature of Funeral Service Lightsee	2. Name and Address of Facility Briscoe- 2294 Old Washington F	Tonic Funeral Home
			23a. Pkrt 1. Enter the etsease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	er the mode of dying, such as cardiac or respiratory a	rrest, Approximate Interval Between Onset and Death
Ö	Physician/ Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of	asovarny office	<i>X Y Y Y Y Y Y Y Y Y Y</i>
	Lammer	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	- Encephalopa	Iny I
	executed an and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):	my o patting	
09.		dical	d		
Box 68760	that the death certificate be ned by the attending physici e detached for use as the bu	Physician/Medica	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death 3 □ Pregnant at time of death 5 □ Unknown	☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery Month Day Year
s, P.O.	requires that the been signed by should be detact	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
of Vital Records,	≥ S S	Completed	COPD	24a. Was	s an 24b. Were autopsy findings available prior to completion of cause of death?
al Re	ician; The la certificate ha rector, page	Be Cor	25. Was case referred to medical		2 No 1 Yes 2 No
of Vit	Physician: r this certific eral director,	은	examiner? 1  Yes 2 No Hospital: 1  Inpatient 2  ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of		idence 6 Other (Specify) how injury occurred
ion	Attending Physician: er death. ector: After this certific by the funeral director,	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury 2 Accident Investigation 3 Suicide 6 Could not be	work? 1 ☐ Yes 2 ☐ No	
Division	tal or Atten rs after deal al Director: ed in by the		4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		(Street and Number or Rural Route Number, wm, State)
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in L	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death only one)  1 Medical Examiner: On the basis of examination and/or investoring Nurse Practitioner: To the best of my knowledge	stigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner stated
_	To th withir To th	_	29b. Signature and title of certifier	29c. License number  D-0057708	29d. Date signed (Month, Day, Year)
	Da-14		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	602
	Sta		31. Date filed (Month, Day, Year) 3 2012 32 Registrar's Signature	RD, WALDORF, MD 200	VU
	Registr	ar	out to to to plant of. If		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 10 20°12 Mary Charlotte Christie 12:27p <sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4709 B Elmer Derr Road Frederick Frederick If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Months Days Hours Min. (Month, Dav. Year) Director 177-01-0518 1 □ M 2 🖾 F 99 Jan. 4,1913 Usual Residence of Decedent Pennsylvania item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4709 B Elmer Derr Road 21703 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien is marked other tl Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Homer L. Dick Nettie Grace Short 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health are Important: If item 27 is any injury or other transcence. Beverly Phebus/ Daughter 4709 B Elmer Derr Road, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Resthaven Memorial Gardens Frederick, Maryland. 4 Donation 5 Donation 21. Signature of Fur ral Service 32. Name and Address of Facility
Stauffer Funeral Homes
1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Scienosis Immediate Cause (Final ATHERO Physician/ Arctery Disense monthy disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** IRANSIEN Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran: that initiated events physician are the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ φ in the past 12 months? Month Pregnant at time of death Day Year the Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 1 Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Af 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifier

A

KAZMI,

BRE

31. Date filed (Month, Day

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MM

814

32. Registrar's Signature

Toll House Aue. FREDERICK

MO 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3 Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 4:45 PM 2012 REBECCA COLE JUNE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL BAY RIDGE HEALTH CARRE ANNAPOLIS, MD CENTER If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Jan 23 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 7 F New Jersey 1921 91 Yrs. 135-26-0067 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Marvland Anne Arundel Annapolis Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ns 23a or 2 must be n 21401 USA 701 Glenwood St. Apt 816 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White etc. Examiner 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify: Specify: Black þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Day Care Self Employed 10th permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 Is marked other i any injury or other traumatic event, <u>th</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unobtainable Unobtainable ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1824 D Copeland St. Annapolis, Md. 21401 Tina Cole(Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 6-15-12 Baltimore, Md. Metro Crematory 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Windame Rovers of Sacilisons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ATHEROSCIEROTIC CARDIOVASCULAR DIJEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine requires that the death certificate be executed physician and is the burial-tran: that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical attending 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4⊡Pregnant at time of death 5 Other (specify) □Yes 2☑No P.O. 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ KENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No ATRIAL FIBRILLATION performed certificate END STACE DEMENTIA 2 INC 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No P

Division or Vital this After or Attending death. within 24 hours after death To the Funeral Director:

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 📝 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

(Check only

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

CKNP

1488878

June 4,2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 VAN BUREN STREET, ANNAPOLIS MD 21403 CAMILLE LOANZON

31. Date filed (Month, Day, Year) JUN 13 2012 32. Registrar's Signature

Certification:

Medical

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Manyland / Department of Health and Mental Hygiene

Bernar	rd Joseph		1- For State	tate (	of Maryla	-	ertificate or	f Health and Death	Mental		Reg. No. 2 (	012 2065		
Medic	Physici al Exam	an/	Registrar  1. Decedent's Name (First, Mid Bennand	dle,Last)		seph	Даи	idson		2. Date of Dea Month June 5, 2	ath Dav Year	3. Time of Death		
	a, Exam		4a. Facility Name (if not institu 24355 Widgeon Pla					4b. City, Town, or I			4c. County of			
	Funeral		5. Social Security Number				. last birthday)	If Under 1 Year		Hrs. 8. Date of B		9. Birthplace (State or		
	Director		119-32-7462		M 2□F	72	Months Dave Hour			Min. Dec.	Foreign Country) N. Y.			
			Usual Residence of Decedent		··· - <u>-</u>			·		200				
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	e Mar or 28a	Director	24355 Widg.	0 <b>n</b>	Degas			10f. Zip Code 2166	; 3		10g. Citizen of Wha $\mathcal{U}_{ullet}$ $\mathcal{S}_{ullet}$			
	death with the Maryland or items 23a or 28a-f show must be ootified at ooce.		11. Marital Status	2016		edent Ever in l	U.S. 13. Wa	s Decedent of Hisp		Specify Yes or No		American Indian, Black,		
	r item	Funeral	1 Never Married 2 X	Married	Armed Fo	orces?		es, specify Cuban,			White,	etc.		
	after (	by F		- 1	or Dates:	r		Yes 2 No				Vhite		
	hours fram		15. Decedent's Education (Sp Elementary/Secondary (0-12		y highest grad College (1			t's Usual Occupationst of working life.			16b. Kind of Bus	·		
36	permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be ootified at occ.	Completed	1 2	,	- 0 -		Insura	ince Ads	juster	2	Insu	rance		
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	be fill antal H irked	Be			idson					rabeth				
0 21	should and Me	٩	19a. Informant's Name/Relation			- /11:0-					mber, City or Town,	21//2		
Σ.	and 2 ealth a	ŀ	Virginia H.  20a. Method of Disposition	Dai	υλαδοί	7/WZZe 20b.	Place of Dispos	フールとは g e ition (Name of cem	on Pla	Date	20c. Location - (	とろ, パル。 City or Town, State		
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	be executed sician and urial - transi	dical	UNPENDED		AMENDED									
1760			IF FEMALE: 23b. Was decedent pregnant in	the	23c. If yes, o	outcome of pre		al death 3	Ectopic pred		23d. Date of d			
Box 6876(	h certil tending use as	ciar	past 12 months?			ant at time of d	loath -	aldeath 3 <u>L</u> ner (S <i>pecify</i> )	_Ectobic bies	grianicy	IVIOITITI	Day Year		
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Š	law requi has been 2 should	Completed			_					autop	osy pri-	or to completion of cause of ath?		
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× ×	l or Attend after death Director: d in by the	Ęį	3 Suicide 6 Co	ald not be	28e Place	of Injury - At h	nome, farm, stree	t, factory, office bu	ilding, etc.	28f. Location (		or Rural Route Number, City		
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	To the within To the comple	Med	29b. Signature and title of certi	a	and manner st			29c. License				(Month, Day, Year)		
			The W	V.	d m	`		O.C.M	I.E. 0	OME	June 6, 2012	2		
		-	30. Name and address of person	n who co	moleted cause	e of death (Iter	n 23a)	<u> </u>		-	I			
RS	10		Theodore M. King, J					900 W. Baltimo	ore Street,	Baltimore, MI	D 21223			
		ate	31. Date filed (Mont) (1) Y	8 20	12 32. Re	strar's Signat	ture /	ales!						

			Please	Type or Pri							egible	
			For State	State of Ma	aryland		partment of I		Mental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle, La	st)			ertificate of L	Jeatn	2. Date of De	Reg. No.	201	2.2065
	Physicia Medic	al	Hugh (	Collins	•	DA			Month	Month, Day Year 1129		
	Examin	er		OSPITAL			4b. City, Town, o	ALBO				
H	Funeral Director	1	5. Social Security Number 6. S 375-01-0782	Sex 7. Ag	e (In yrs. las 4	st birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Co	thplace (State or Foreign untry) chigan
	or Jow	'n	Usual Residence of Decedent  10a, State 10b, County		10c. City.	, Town or L	ocation				1111	10d. Inside City Limits
:	Marylar 28a-f sl otified	Director	Md. Talbo	t		rapp						1 ☐ Yes 2 📈 No
:	th the	al D	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Co	ountry?
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036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 🌠 Widowed 4 ☐ Divorced	Armed Forces?  1 N Yes 2 If Yes, Give Year or Dates.			If Yes, specify Cuba 1 Yes 2 No	an, Mexican, Puerto	Rican, etc.)		Black, Whit	
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Baltimore, Maryland 21215-0036	within /s giene. er than the Me	<b>Completed</b>	Elementary/Secondary (0-12)	College (1-4 or 5	ō+)	life.	irman of			Amer	ican	Pipeline
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<b>≅</b> ₹	12 sho alth an 27 is rtrau		Margaret M. Da		ter	1	ling Address (Street					
Je,	of Hear of Hear fitem		20a. Method of Disposition		20b. Pla	ace of Disp	3 Chance cosition (Name of ternatory or other place			20c. Location	on - City or	Town, State
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Ba	Depar Impor any In		21. Signature of Funeral Sovice Licer	see			22. Name and Addre	<sup>ss of Facility</sup> Bei e Stree	nnie Si t,Camb	mith 1 ridge	Tune:	ral Home
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line	Э.		4	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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687	nding phuse as t	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnan	ıcy				23d.	Date of de	livery
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3	ne nosp in 24 hou ne Fune pletely fi	Medical	(Check 2 \(\sumeq\) Medical Exam	ysician: To the best of niner: On the basis of e rse Practitioner: To the	xamination	and/or inve	stigation, in my opini	on, death occurred a	at the time, date a	and place, and	due to the	cause(s) and manner stated.
- 1	Nith E	_	29b. Signature and title of certifier	ond man.	100	1 March	29c. Licens			29d. Date sig	/ /	
	TIS		30. Name and address of person who	completed cause of d		23a) (Type		018410		06/	01/2	2012
	ITVA		Laura M Mu	inford r	MD	10	155 Fal	ls Rd	Luthe	rville	MI	21093
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Gladys Edmonds

			Please I	ype or Print in				_	-	
		-	For State	State of Marylan					201	2 2065
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Jeann	2. Date of Dea	Reg. No.	Z Z U O J
Phys			Glady	Geneva	FJ.	1		Month	Day Year	3. Time of Death 2 2035 M
	edica mine	_	4a. Facility Name (if not institution, give str		_ La M	4b. City. Town, or	r Location of Death	June	4c. County of Dea	
			Salisbury Rehabilit	mlion eNure	mete	Sal	lisburg	١	Wicon	
Fune	ral		5. Social Security Number 6. Sex	7. Age (In vrs. la	ast bilthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		h <b>I</b> 9. Bi	irthplace (State or Foreign
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nd how at	4	- 1	Usual Residence of Decedent  10a. State 10b. County	10c, Cit	y, Town or Lo	cation				10d. Inside City Limits
arylaı la-fs		ectc	Maryland Wicomia		Ede	<b>n</b>				1 ☐ Yes 2 💢 No
the M or 28		ैं	10e. Street and Number		200	10f. Zip Code			10g. Citizen of What C	country?
with s 23a	n sem	Funeral Director	4067 Dishar	von Rd.		218	327		U.S.	Α
death item	į.		11. Marital Status	2. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
after after ll", or xami	Yall	à l	1 ☐ Never Married 2 ☐ Married  3 🌠 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		☐ Yes 21 No				acK
21215-0036 within 72 hours after gjene. er than "natural", o t. the Medical Exam	Za l	Completed	15. Decedent's Educ	Year or Dates.	16a, Deced	ent's Usual Occup	pation		16b. Kind of Business	
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withii giene giene the the			8th grade		Lin	e Wor	rker		Campbell	Soup. Co.
nd filed tal Hy d oth		To Be	17. Father's Name (First, Middle, Last)	0 10 7			1		Maiden Surname)	
Ya Jahan Jahan Jahan Jahan Jahan Jahan		-	Arthur W.	Banks	Т		Cecil	•	lickens	
Maryland 12 should be filed with and Mental Hy 27 is marked oth			19a. Informant's Name/Relationship (Type		19b. Mailir	_			; City or Town, State, Z	(ip Code)
and and the Healt term 2		ŀ	Carolyn tamonds  20a. Method of Disposition	-Daughter		sition (Name of	aroon Ro	Date Date	20c. Location - City of	ur Town State
age 1 ent of nt: If if			1  Burial 2  Cremation 3  Re 4  Donation 5  Other (Specify)	emoval from State	emetery, cren	natory or other place		6-12	Fruitlan	4
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any iniux or other traumatic event. the Medical Examiner must be notified at	i oj	1	21. Signature of Funeral Service Licensee			YU.M.C. C			E. Ward	F. H.
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LAdiiii	•	۱ ٪	Sequentially list conditions, b.	Tartin	150n	7 01	1 > ellec			feers
sit sd		Examiner	air any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequ	delice oi).					
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Box 6876( death certificate the attending phy led for use as the		Physician/Medi								
certi endin	1	an	23b. Was decedent pregnant	c. If yes, outcome of pregna		Ectopic pregnanc	CV		23d. Date of d	elivery
BOX death he att ed for		SICE	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of of 9 ☐ Unknown		Other (specify)	-,		Month	Day Year
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e come e law e has ge 2 s		ğ					<u></u>	autop perfor	rmed? prior to death?	completion of cause of
an: The tifficate tifficate toor, pe	•		25. Was case referred to medical			26. PI	lace of Death (Chec	1 Yes	2 K No 1	es 2 No
Vita ysicia is cer direct		0 0	examiner? 1 Yes 2 No	spital:	ER/Outpatien	t 3 🗆 DOA Othe	er: 4 Nursing H	ome 5 Resid	ence 6 Other (Spe	cify)
of ng Ph fter th meral			27. Manner of Death  1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injun work		28d. Describe h	ow injury occurred	
ion tendii leath. tor: A: the fu		≌	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 No			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  The abrector: After this certificate has been signed by: ad in by the funeral director, page 2 should be detabled in by the funeral director, page 2 should be detabled.		Certificate:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		et, factory, office		28f. Location (S City or Town	treet and Number or Ri n, State)	ural Route Number,
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the		g	29a, Certifier 1 Certifying Physici	ian: To the best of my knowl	ledge, death o	ccured at the time	e, date and place, a	nd due to the cau	use(s) and manner as s	tated.
n 24 h		Medical	(Check 2 Medical Examine	r: On the basis of examination Practioner: To the best of my	n and/or invest	igation, in my opinio	on, death occurred a	it the time, date ai	nd place, and due to the	cause(s) and manner stated
Vithii To th	'	— г	29b. Signature and title or certifier			29c. License	e number	:	29d. Date signed (Mon	th, Pay, Year)
40.			MoTum	h		100	8769	-	6/11	112
XX				npleted cause of death (Item	23a) (Type, F	rint	Aux S	alish	u 11.1	21804
7	Stat		Vicholar Boralu  31. Date filed (Month, Day, Year)	82. Registrar's Signat	ture	0,0,0,	, ,,,,	C 13.00	11	01007
Regi	State istra			012 Cenus	1.	bace				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G929 7/13/2012 JH State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20, Day 2012 Year Physician/ Jumeth 3:20A. Alexander Foster, III Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Greenbelt 122 Rosewood Drive Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 🕅 M 2 🗆 F Days Hours Min July 2, 1931 250-42-9137 80 Georgia **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Prince George's Greenbelt 1 Yes 2 ☐ No 10e. Street and Number o 10f. Zip Code 10g. Citizen of What Country? 23a c Funeral 20770 United States 122 Rosewood Drive Page 1 and 2 should be filed within 72 hours after death or items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 448-1970
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: "natural", Completed 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 o5 5+) Elementary/Seconday (0-12) Computer industry Computer Programmer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Alexander Foster, II Sarah Buckner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
122 Rosewood Drive Greenbelt, Maryland 20770 19a. Informant's Name/Relationship (Type, Print) Helen Robinson Foster -wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem. (unk) 07/05/2012 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Bonald V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Concestive Heart Failure Medical resulting in death) Due to (or as a consequence of) Examiner Coronary Artery Disease Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Degenerative Disk Disease; Charcot-Marie-Tooth disease; 1 Yes 2 No 3 Probably 4 Unknown Completed Atrial fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 III No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number June 20, 2012 D50566 bu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samer Najjar, M.D. WHC 110 Irving Street, NW Washington, DC 20010 Month, Day, Year, 28 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2 Date of Death Monthune Physician/ 0145 Helen Mae Faith 2012 Medical 4c. County of Death
Washington Facility Name (if not institution, give street and number)
Meritus Medical Center 4b. City, Town, or Location of Death Examiner Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Yea 7-5-1937 192-30-4561 74 Chambersburg PA 1 □ M 2**X**□ F Director Usual Residence of Decedent 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Clear Spring MD Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14524 Mercersburg Road 21722 U,S.A. death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: white an "natural", o 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Mean injury or other traumatic event. glass mfg. co. Elementary/Secondary (0-12) College (1-4 or 5+) office clerk 12th grade Be Father's Name (First, Middle, Last)
Melvin E. Robinson 18. Mother's Name (First, Middle, Maiden Surname) Helen Viola Reeder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14524 Mercersburg Rd. Clear Spring, MD 21722 Joseph Faith husband 20b. Place of Disposition (Name of 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 6-16-2012 cemetery, crematory or other pla Little Rose Hill Clear Spring, MD Donation 5 Other (Specify) Symmure of Funeral Service Licenses 2 Name and Address of Facility Donald Edwin Thompson Funeral Home, P.O.BOX 310 Clear Spring, MD. 21722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury -transit The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) for in the past 12 mop Month Dav Year Pregnant at time of death signed by the a 2 No Unknown 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has page 2 autopsy performed 2 No 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending Natural worl 1 🗌 Yes 2 🗌 No filled in by the Accider Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier Signature

Registrar
DHMH 17 Rev 06-2011

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strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 2012 4:42 Рм Charles Russell Favorite Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 214-34-0269 Hours Min Country 74 Director 1 🖾 M 2 🗆 F Dec 10, 1937 Maryland 28a-f show 10b. County aţ 10a. State 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Frederick Thurmont 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21788 USA 109 Redhaven Court within 72 hours after death Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 K Married þ 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Superintendent other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Madeline Davis Charles Russell Favorite, Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Patricia Favorite - wife 21788 109 Redhaven Court, Thurmont, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Blue Ridge Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State 6-13-2012 Thurmont, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final nset and Death herosclerone ndis Vascular Physiciani disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician; The law requires that the death certificate be executed and -trar Due to (or as a consequence of): resulting in death) Last burialding physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Q Month Day Year the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? After this certificate 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Hospital 2 No ည 1 Tes 1 Inpatient 2 ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature and title of certifier D0035152 6-11-12 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

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32. Recistrar's Signature

KRANR

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Physician/ 13:40 PM 2012 William Lee Foulk June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital of Cecil County Cecil E1kton If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Numbe Funeral Year) 1 XM 2 □ F Months Davs Hours Director 92 1920 Tennessee 171-34-6850 Jan Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10a. State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 72 hours after death with the Maryland Director 1 Yes 2XXNo Maryland Cecil North East 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21901 United States 33 Dr. Carr Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black, White, etc. Yes 2 No Yes, Give 1XXNever Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Cabinet Manufacturing 6 Laborer permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Lawrence A. Foulk Elizabeth (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Violet Moore / Sister 6033 Wilson Terrace, Sebring, Florida 20c. Location - City or Town, State 20b. Place of Disposition (Name of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State State Line Baptist Cemetery Rising Sun, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ leans disease or condition Medical resulting in death) Due to (or as a conse de ce of) Examiner Sequentially list conditions Examiner Due to (or as a consequence or) it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day 2 🗌 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2: autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospital Other: 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours efter death.

To the Funeral Director After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title

State Registrar 30. Name and address of pers

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6.7.2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7: 55:2 2013 homas 90 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Julia Manor Healthc Hagerstown *washington* are 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last hirthday **Funeral** Months Oct.20,1943 Maryland Director 220-40-0454 1 🗙 M 2 🗆 F 68 Usual Residence of Deced show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location at Funeral Director must be notified 1 Yes XX No 28a-f Maryland Washington Hagerstown 10f. Zip Code 9 10e. Street and Number 10g. Citizen of What Country? 23a 21740 USA 333 Mill Street items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Black, White, etc. 1 X Yes 2 □ No Korea If Yes, Give Year or Dates. 9 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Widowed 4 X Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) alth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ruth Giffin Charles Edward Giffin Alice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14871 Robinhood Circle Greencastle, PA 17225 Health rem 27 Teresa E. Lewis - Daughter other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any injury or o once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State June 20,2012 Sharpsburg, Maryland Mt. View Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Funera 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph<sub>sician/</sub> disease or condition resulting in death) Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examine ve Heart Failure the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar resulting in death) Last physician Physician/Medical Mellitus liabetes Division of Vital Records, P.O. Box 68760 the signed by the attending p d be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by PER:pheral Vascular Disease, pulmonary 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Hypertension, Old Myocardial Infarction 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼ No 24a Was an autopsy 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?

1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, မ 28c. Injury at work? 1 ☐ Yes 28a. Date of injury (Month, Day, Year) 28b. Time of 27, Manner of Death 28d. Describe how injury occurred 1 Natural Medical Certificate: 5 Pending s after death. 2 🗌 No thef Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Funer

completely fi 29a. Certifier (Check 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) R125360

State Registrar

TW-1

P-333 M:11 Street, Howerstown, MD21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physician/ ical Examiner  1. Decedent's Name (First, Middle, Last)	abeth Anne (	Gar	otato of Marylana / Bop	partment of e <i>rtificate</i> of		d Mental H		. No. 2	012 2065
4. Fieldly Name of and institution, your period and muchasis and the property of the property			Decedent's Name (First, Middle,Last)	er				Day Year	
214-13-7961							h	4c. County o	
The companies of the			214-13-7961 1_M 2XF 30		Months Days			,	
20. Nemocratic Clause (Fine) disposition of the proposition of the property of other piece)  21. Standard of the property of the price of Disposition (Name of cometery, or other piece)  22. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  230. Name and Address of Facility Bast—Stauffer Funeral Home, PA  231. Name and Address of Facility Bast—Stauffer Funeral Home, PA  232. Date of Cardior Stauffer Funeral Home, PA  233. Date of Gast—Stauffer Funeral Home, PA  234. Date of Gast—Stauffer Funeral Home, PA  235. Da	r death with the Maryland or items 23a or 28a-f show must be notified at once.	Be Completed by Funeral	10a. State 10b. County 10c. Ci  Maryland Washington  10e. Street and Number  217 Willard Street  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)  4  17. Father's Name (First, Middle, Last)  Gary A. Lapole	U.S. 13. Was If Ye 1 1 16a. Decedent during mc Admi	WIN  10f. Zip Code 2174  s Decedent of Hispes, specify Cuban, Yes 2 No I's Usual Occupations of working life.  nistrati	panic Origin? (S Mexican, Puerto specify: on (Give kind of DO NOT use ret VE ASSIS 8.Mother's Name	work done tired) stant e (First, Middle, Maah S. Th	U.S.A  14. Race White, Specify:  6b. Kind of Bus  Electr iden Surname)	A. American Indian, Black, etc.  White  iness/Industry  cical
Thysician fairur. List only one cause of death. Do not entire the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairur. List only one cause of death of the cause of the death. Do not entire the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairur. List only one cause of death of the cause of the death. Do not entire the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairur. List only one cause of death of the cause of the death. Do not entire the mode of dying, such as cardiac or respiratory arrest, shock, or heart fairur. List only one cause of death of the cause of the death of Doath of the cause of the death. Sequentially list conditions, if any, leading to immediate cause. Enter fundrying death of the cause of death of Doath of Cor as a consequence of):    Part II. Other significant conditions	s l and of Healt li item		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify:	Place of Disposi crematory or oth tauffer (22. N	tion (Name of cemer place) Cremator ame and Address	y 06 / of Facility Bas	Date /14/2012 st-Stauff	Frederi er Fune	ck, Maryland
Part II. Other significant conditions   23e. Did tobacco use contribute to the cause of death?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 3   Probably 4   Unknown   24a. Was an autopsy performed?   1   Yes 2   No 1   Yes 2	be executed SE	an/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  Due to (or as a consequence consequence domain and consequence by the consequence domain and consequen	of):  of):  of):  per me, g  ignancy 2  Fet:	<b>5930 8-1</b> 3	3-12 sm			lelivery
30. Name and address of person who completed cause of death (Item 23a)	To the Hospital or Attending Physician: The law requires that the deat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the at completely filled in by the funeral director, page 2 should be detached for	Certification: To Be Completed by	Part II. Other significant conditions contributing to death but not 25. Was case referred to medical examiner? 1  Yes 2  No  Hospital: 1  Inpatient 2  27. Manner of Death 1  Natural 5  Pending Investigation 3  Suicide 6  Could not be determined (Specify)  29a. Certifier 1  Certifying Physician: To the best of my knowle one) 2  Medical Examiner: On the basis of examination and manner stated.	ER/Outpatient 28b. Time of In home, farm, street	26.Place of 3 DOA Conjury 28c. Injury 1 Yest, factory, office but ded at the time, dat on, in my opinion, 29c. License	of Death (Check Other 1 Nursin v at Work? es 2 No uilding, etc. e and place, and death occurred a	1  Yes  24a. Was an autopsy perform 1 ✓ Yes 2  only one)  ng Home 5  Re  28d. Describe how  28f. Location (Str or Town, Stail  d due to the cause( at the time, date an	2 No 3  24b. W point de	Probably 4 Unknown ere autopsy findings available for to completion of cause of eath? Yes 2 No  Other: Scene  d  or Rural Route Number, City as stated. e to the cause(s)  d (Month, Day, Year)
				•					12

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 2012 ar 10, Roy Earl Garrett 1:00 Рм 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2501 Catoctin Ct., Unit 1-B Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 254-34-6788 88 1 🛛 M 2 🗆 F Feb. 25, 1924 Georgia Usual Residence of Decede 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2501 Catoctin Court, Unit 1-B 21702 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married X Yes 2 No If Yes, Give Year or Dates. WWII 1 ☐ Yes 2 X No Specify: Specify.White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Laundry Engineer Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Garrett Zuma Cannon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen T. Garrett / Wife 2501 Catoctin Ct., Unit 1-B, Frederick, MD 21702 20a. Method of Disposition 20b. Place of Disposition (Name of carnetery, crematory or other place) Memorial Gardens 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2012 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature Funer ervice Licensee 22. Name and Address of Facility. Stauffer Funeral 1621 Opossumtown Homes, P.A. Pike, Frederick, MD 21702 m01237 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart Interval Between Immediate Cause (Final Onset and Death disease or condition resulting in death)

Physician/ Medical **Examiner** 

> burial-tran physician the burial

as nse

signed by

To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate h completely filled in by the funeral director, page

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Examiner

**Funeral** 

**Director** 

28a-f show

ō

23a

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Experimental Once.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

Funeral

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Completed

Be

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shock

27. Manner of Death

Natural

3 ☐ Suicide 4 ☐ Homicide

only one)

29a. Certifier

29b. Signature

Accident

5 Pending

and title of certifier

Investigation

determined

6 Could not be

with the Maryland

Examine Completed by Physician/Medical After this certificate has been sidented functions of the sector, page 2 should I Be ြု Certificate:

cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last  c.  Due to (or as a consequence of):  d.		
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   24   Pregnant at time of death 5   Other (specify)   9   Unknown   9   Unkno	23d. Date of de Month	elivery Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to	
	autopsy prior to performed? death?	utopsy findings available completion of cause of s 2 \square No
25. Was case referred to medical examiner?  1  Yes 2  OOA  Hospital: 26. Place of Death (Che	ck only one)  Home 5 Residence 6 🗆 Other (Spec	260

28c. Injury at

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 06-2011

State Registrar 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of injury (Month, Day, Year)

MD. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RGIL Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Vantage House Columbia Howard Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months Hours (Month, Day, Year) Director 577-16-6886 1 🔀 M 2 🗆 F Yrs 91 11/02/1920 SC Usual Residence of Decedent 28a-f shov 10a, State 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2 No Columbia MD Howard 10e, Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 5400 Vantage Point Rd - Cedar Place 21044 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 

Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify. Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) injury or other traumatic event, the General Foreman Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Oscar Virgil Gentry Lucy Annie Culpepper Health and I tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 233 East Skyline Drive Purcellville, VA Paul V. Gentry - Son 20132 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD Crownsville Vet. Cem. 06/19/2012 21. Sign ture of Funeral Service License 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. uanta 4112 Old Columbia Pike Ellicott City, MD 21043 Momas 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Que to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 2 🗌 No 1 ☐ res ∠ ☐ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed 2 1 No 1 🗌 Yes Yes 2 -Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 **N**o 1 🗆 Yes Other: ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After Hospital or Attending to hours after death. Natural 5  $\square$  Pending Accident 1 Yes 2 No filled in by the Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 30. Name and address cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

Box 68760

P.O. 1

Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Charles G. Grover Day 2012 ear 7:30A. Jumeh 2, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 3160 Gracefield Road, RC#1203 Silver Spring Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🔀 M 2 🗆 F Months Hours Jume 17, 1915 96 Utaty) 579-24-2471 **Director** Usual Residence of Decedent 28a-f shov 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Prince George's Silver Spring 1 🗆 Yes 2 🗗 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 20904 United States 3160 Gracefield Road, RC#1203 be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 X Yes 2 No If Yes, Give Year or Dates. WWII 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Medical Examiner Black, White, etc. ō, þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White Specify: "natural", Completed 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Federal Government Engineer ath and Mental Hygie
27 is marked other
r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles S. Grover Martha Millgate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12037 Remington Drive Silver Spring, MD 20902 Department of Health ar Important: If item 27 is any injury or other trau once. Timothy P. Lee -Guardian 20a. Method of Disposition
1 □ Burial 2 ☑ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Metropolitan Crematory 6/4/2012 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonald V:Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attendin I be detached for use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4X Unknown certificate has been si irector, page 2 should l 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 🗌 Yes 2X No Yes 2 XNO To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D59524 June 22, 2012 oulen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Loveen J. Puthumana, MD 3110 Gracefield Road Silver Spring, Maryland 20904

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 12 Day 2012 Marion Lee Holland Medical 4a Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death mico If Under 1 Year If Under 24 Hrs.

Months Days Hours Mig. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 1 M 2 □ F 216-14-9796 91 Sept. 6, 1920 Maryland and Merital Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Exeminar must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Worcester Pocomoke City 1 Yes 2 1 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4245 Fleming Mill Road 21851 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo
If Yes, Give ģ 1 Never Married 2 X Married 1 Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Farmer Agriculture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marion S. Holland Margaret Tull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21851 permit. Page 1 and 2 shr Department of Health an Important: If Item 27 is any Injury or other traus Gladys Holland/ wife 4245 Fleming Mill Road, Pocomoke City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 🗋 Donation 5 🗀 Other (Specify) Pitts Creek Cem. 6/16/2012 Pocomoke, MD Signature of Full@ral Service Licenses 22. Name and Address of Facility Holloway Funeral Home P.A. Me 107 Vine St., Pocomoke City, MD 21851 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BMBN ease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month 5 Other (specify) 1 Yes 2 No q | Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA HUSPICE 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural

Accident 5 Pending Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Hugu 130 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 12:30 p M Ellen Viola Hubbard TUNC 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie Anne Arunde BAltimore Washington Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) 577-34-2458 1 □ M 2 🛣 F Director May 10, 1929 83 |Washington, DC Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Iftem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Middlesex Hartfield Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23071 JSA 35 Beach Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ David Puesy Wood Hazel Viola Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st.
Department of Health an
Important: If item 27 is 1
any injury or any 7948 Roxbury Drive Glen Burnie, MD 21061 Linda Marie Taltavull/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Memorial Gardens 20a. Method of Disposition
1 \( \overline{D} \) Burial 2 \( \overline{D} \) Cremation 3 \( \overline{D} \) Removal from State 20c. Location - City or Town, State 6/14/2012 Waldorf, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home M01164 3035 Old Washington Road Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PNeumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D027415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAltimire Washington Medical Center 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ George Thornton Harrison, Jr. Month June 2012 2:55 PM Medical 4a. Facility Name (if not institution, give street and number)
Heartlands of Severna Park 4b. City, Town, or Location of Death Examiner 4c. County of Death Severna Park Anne Arundel 5. Social Security Number 227–32–7515 8. Date of Birth (Month, Pay, Year) May 11, 1931 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Virginia Director 1**XX**M 2 □ F 81 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 No 10e. Street and Number 705 Holly Drive North 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? ★★Yes 2 □ No If Yes, Give 1951— Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Year or Dates. 1951-55 "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, <u>the Menay injury or other traumatic event</u>, <u>the Menay injury or other traumatic event</u>, College (1-4 or 5+) Elementary/Secondary (0-12) Electrical Engineer Consulting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George T. Harrison Emma Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elssie Harrison/wife 705 Holly Drive North Annapolis, Maryland 21409 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore Crematory 6/14/2012 | Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home odd 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Parkinsons Disease years Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injuly that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death 5 Other (specify) Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è cate has been signer, page 2 should be c Completed | 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate | director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 2XX No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 🛛 Natural iniury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D17965 June 12, 2012 30. Name and attress of person who completed cause of death (Item 23a) (Type, Print)

State Regis<u>trar</u> Joseph Friend

JUN 13 2012

31. Date filed (Month, Day, Year)

Annapolis, MD 21401

116 Defense Highway

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 21° 2012<sup>xear</sup> Helen M. Hawkins June 2:00A. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Renaissance Gardens at Riderwood Village Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 579-40-7445 New York 1 🗆 M 2 🖔 F **Director** 82 Yrs June9,1930 Usual Residence of Decedent or 28a-f show e notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral 3112 Gracefield Road, 20904 PV#201 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or i edical Examin þ 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Correspondence Financial Publication Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of William MacColl Helen Connelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 3112 Gracefield Road, PV#201 Silver Spring, MD 20904 Donald K. Hawkins -husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c, Location - City or Town, State Date 1 to ☐ Burial 2X Cremation 3 ☐ Removal from State Department of Important: If any injury or 6/21/2012 Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licensee Donald dovor Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death 10 years Physician/ Arteriosclerotic Cerebral Vascular Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Atrial Fibrillation 10 years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hypertension Cause (Disease or injury 10 years nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 23d Date of delivery in the past 12 months?

1 Yes 2 No Year Pregnant at time of death ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Type II; Coronary Artery Disease Records, 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2X No death? After this certificate 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death. Accident Suicide Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in tity opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year)

State Registrar Eileen Gemmell, CRNP 3160 Gracefield Road Silver Spring, Maryland 20904

31. Date filed (Month, Day Year)

32. Registrar's Signature

Name and address of person who

pleted cause of death (Item 23a) (Type,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Barbara K. Johnson June ľŎ 2012 6:32 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 48 Murray Ave Annapolis Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Davs Hours Maryland Director 217-26-1616 82 Aug 929 Usual Residence of Decedent or 28a-f shov notified at show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 48 Murray Ave 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2X No Specify: Specify: 3X Widowed 4 □ Divorced **Black** Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Rhinestone Setter Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Smith Lillian Kyler 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Bonnie Sembly (Daughter) 48 Murray Ave Annapolis, Md. 21401 other ! Baltimore, 20a. Method of Disposition 20b.HacelofDispGstrom Same of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 6-15-12 4 Donation 5 Other (Specify) Annapolis, Md. 21. Signature of Funeral Service Licenses Windame a Receise of RecilitiSons Mortuary, 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on pach line. Interval Between Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequ Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or asja consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linium that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant g Unknown 5 Other (specify) Month Dav Year Pregnant at time of death Yes signed by the a Id be detached f Unknow Part II. Other significan onditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been a funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an perform 2 🗆 😘 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 1 Tes 2 🗆 ျ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injun 5 Pending work? 1 ☐ Yes 2 ☐ No after death Investigation Accident
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Homicide completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined e Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 L within 2 To the F only one 29b. Signature and tine 29c. License number 29d. Date signed (Month, Day, Year, 30. Natine and address of person who completed cause of death (Item 23a) (Type, Print) 1 NTHIEUM State JUN 13201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 6 22 Medical 4a. Facility Name (if not institution, give street and number) Cocation of Death **Examiner** 4b. City, Town, 4c. County of Death Prince inton Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under Min 743 - 34-Director 401 1 🕻 M 2 □ F 83 13-1929 North ıral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MARYLAND Clinton George 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 459 7522 20735 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No 195 Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 🗌 Widowed 4 🗌 Divorced Completed Black Year or Dates. or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 00 is marked other than State Elementary/Secondary (0-12) College (1-4 or 5+) MARYIA PERVI 013 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health ar Important: If item 27 is any injury or other trau Rd Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Donation 5 D Other (Specify) 21. Signature of Funeral Service U 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Approximate Interval Between Immediate Cause (Final disease or condition Myo Cardiol inforction Onset and Death Phylician Medical resulting in death) Due to (or as a consequence of): Examiner TRAS, 10 Facultially list nondificing if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events coulding in double). Let Due to (or as a consequence of Exami CUA trar Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buris Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burn completely filled in by the funeral director, page 2 should be detached for use as the burn Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No \_\_ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No 잍 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature 3 201 Registrar

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Division of Vital Records,	or Attu fter de irecte n by t	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	28e. Place	of Injury	- At home, farm Specify)	street, fa	ctory, office		2	8f. Location (S City or Town		d Number or Rui	al Route Num	ber,
۵	pital o		00 0 10 15	7	4						4					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  The Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 (Check 2 only one) 3	Medical Exa	ysician: To the b niner: On the bas rse Practioner:	sis of exar	mination and/or in	vestigatio	n in my oninion	death occ	urred at the	he time date ar	nd place	and due to the c	ause(s) and m	anner stated.
	vithir To th			le of certifier	/	TO THE DE	ot of my knowled	ge, death	29c. License		and place,	_		e signed (Month		
	715		30. Name and addres	S of person who	Vemor	e of deat	th (Item 23a) (Tim	e, Print)	ROT	<u> 131'</u>	4-	5	6	-12	-18	<del>}</del>
	6	$\perp$	Miche	ele 1	2500	1	610		CHMAN	is h	ANE	E	7STC	M MM	210	100
	State Registra	_	31. Date filed (Month,	Day, Year) 1 2 20	2 32	egistrar's	Signature .	back								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHRISTINE MARIE KOLB 1833 Medical JUNE 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.

A the Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Days (Month, Day, Year) Director 79 099-26-6842 1 □ M 2 🖺 F 01/25/1933 Usual Residence of Deceder NY 28a-f shor 10a. State 10b. County the Maryland the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Howard Columbia 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a within 72 hours after death with 6045 Misty Arch Run 21044 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, ō Ś 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked ၉ Department of Health and Ment:
Important: If item 27 is marked
any injury or or or Peter Paul Graf Christine Marie Imhof 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 751 Holliday Lane Westminster, MD Lisa Mitchell - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. 4 ☐ Donation 5 ☐ Other (Specify) Lawn Mem. Gard. 06/18/2012 Marriottsville, MD 21. Sign turn of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Homas 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Brai Anoxic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Day Year ed by the a detached 1 Division of Vital Records, P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should HUPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ဍ 1 Nnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5  $\square$  Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature litle o D62099 30. Name and add completed cause of death (Item 23a) (Type, Print) 10 M MEMORIAL WESTMINSTER, MI 21157 AVE. 7corpe

DHMH 17 Rev 06-2011

State

Registrar

1 5 2012

12-04565 Carol Kaiser

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Carol Kaiser	Sta 1- For State Registrar	te of Maryla		rtment of tificate of		d Menta	al Hyg	iene Reg. I		012 2067	
Physician/ 1. Decedent's Name (First, Middle,Last)  Medical Examiner  Carol Jean Kaiser  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of De											
			nber)	4	b. City, Town, o	Location of [		17, 201		f Death	
Funeral Director		. Sex	7. Age (In yrs. la 54	st birthday) Yrs.	If Under 1 Yea Months Day		24Hrs. 8 Min.	3. Date of Birth (N		9. Birthplace (State or Foreign Country)New York	
3 72 hours after death with the Maryland In "natural", or items 23a or 23a-f show any rel Examiner must be notified at once.	Usual Residence of Decedent  10a. State 10b. County  Maryland Cecil  10e. Street and Number  310 Hollingswort  11. Marital Status  1 Never Married 2 Married	12. Was Dece	dent Ever in U.S		10f. Zip Code			fy Yes or No-		1 States American Indian, Black,	
5-0036 led within 72 hours after d tygiene. other than "natural", or the Medical Examiner. Corripleted by Fi	15. Decedent's Education (Specific Elementary/Secondary (0-12)	If Yes, Give Year or Dates: y only highest grade  College (1-2	e completed)	16a. Decedent's during mos	Yes 2 No s Usual Occupa st of working life fied Nu	tion (Give kine DO NOT use	e retired) Assi:	stant	Home	White iness/Industry Healthcare	
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than 1 antic event, the Medical To Be Corriple	17. Father's Name (First, Middle, Li  Carl Kaiser  19a. Informant's Name/Relationship	(Type, Print)				Be and Numbe	tty _ r or Rura		, City or Town,	, State, Zip Code)	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Be Corriple	Leslie Laliberte  20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other Spec  21 Signature of Fineral Service Light	3 Removal from	20b. Pi	lace of Dispositi rematory or othe yerdale	on (Name of cer place) Cremate	metery,	June 201	22, Ne	e.Location - (	nd 21901 City or Town, State Delaware	
Physician /Medical	23a. Part I. Enter the disease or co- failure. List only one gause or	emplications that cau		127	South 1	Main St	tree	h Funera t, North spiratory arrest,	East.	Maryland21901	
M760, Wilcate be executed B B B B B B B B B B B B B B B B B B B	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unease or injury that initiated events resulting in death) Last  W UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the	Due to (or as a coop.  d.  AMENDED 2	consequence of) consequence of) consequence of) 3a,27,pe	er me,g	<b>929,7–2</b> -	-12 sm	egnancy	-		elivery Day Year	
D.O. Box 68760 that the death certificate the but the attending physicated for use as the but by Physician/Meby	past 12 months?  1 Yes 2 No 9 ✓ Unknot  Part II. Other significant condition	wn 9 Unknow	nt at time of deal	th 5 Othe	(Specify)			23e. Did tobacc		ute to the cause of death?	
Records, F : The law requires ifficate has been sign r, page 2 should be								24a. Was an autopsy performed 1 Yes 2	24b. We pric	Probably 4  Unknown ere autopsy findings available or to completion of cause of ath? Yes 2  No	
ion of Vital treading Physician: teath. for: After this certif the funeral director, the funeral director,	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death  1 ✓ Natural 5 Pending	28a. Date of (Month, D	Injury 2	ER/Outpatient 28b. Time of Inju	3 DOA	of Death (Choother Notes 2 No	ursing Ho			Other:	
Division o  To the Hospital or Attending within 24 hours after death. To the Fuoral Director: Aft completely filled in by the fune ledical Certification:	2	ot be ned (Specify)	of Injury - At hom					or Town, State)		or Rural Route Number, City	
lo the complete of the complet	one) 2 Medical Examir 29b. Signature and title of certifier	lcian: To the best of ner: On the basis of and manner state	examination and			death occurr		time, date and p	olace, and due		
	30. Name and address of person wh		·	•	O.C.N				ine 17, 201	12	
State Registrar	Carol H. Allan, MD As 31. Date filed (Month, Day, Year)	sistant Medica	I Examiner	9	Itimore Stre	et, Baltimo	ore, MD	21223			

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	partment of Health and N ertificate of Death		ene g. No. 201	2 20671
	Physicia	an/	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physicia Medi		VIRGINIA M. LANGRELL		JUNE 5,	2012 Year	12:05 A <sup>M</sup>
	Examir	ner	4a. Facility Name (if not institution, give street and number)  MALLARD BAY NURSING & REHABILITATIO	4b. City, Town, or Location of Death CAMBRIDGE		4c. County of Deat  DORCHE	
	Funeral Director		5. Social Security Number 217–14–8885 6. Sex 1 M 2 M F 89 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, JULY 22	(ear) 9. Birth Con	hplace (State or Foreign untry) MARYLAND
	or at	١	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			
	larylar 3a-f sl ified	Director	MD DORCHESTER CAMBR				10d. Inside City Limits 1   Yes 2 □ No
	or 28			10f. Zip Code	10	g. Citizen of What Co	
	s 23a uust b	Funeral	520 GLENBURN AVENUE	21613		USA	,.
	death item ner m	F	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Amer	
336	after al", or Exami	d by		1 ☐ Yes 2 X No Specify:	,	Black, White Specify:	WHITE
Ŏ-	hours natur dical B	lete	15. Decedent's Education 16a. Dece	dent's Usual Occupation	1	6b. Kind of Business I	ndustry
7	hin 72 ne. <b>than "</b> e Mec	Completed	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	kind of work done during most of work OO NOT use retired)	ng		,
2	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	BeC	11 0 BE	AUTICIAN		BEAUTY	SHOP
Maryland 21215-0036	be file lental l rked o tic eve	일	LUTHER P. MARVEL		e (First, Middle, Ma A E • STE	,	
ary	ge 1 and 2 should be file tr of Health and Mental : If item 27 is marked or or other traumatic eve		19a. Informant's Name/Relationship (Type, Print) DAUGHTER, 19b. Mail	ing Address (Street and Number or Rura	l Route Number, C	ity or Town, State, Zip	Code)
χ. Σ	and 2 s Health em 27 ther tra		KATHERINE A. LANGRELL IN-LAW 379	8 MARVEL DRIVE, TR		21673	
0	ge 1 and nt of Hea : If item or other		20a. Method of Disposition  1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State  20b. Place of Disposerery, cre	osition (Name of matory or other place)	Date 2	0c. Location - City or	Town, State
baitimore,	permit. Page 1 Department of Important: If i any injury or conce.		4 Donation 5 Other (Specify) WOODLAWN	MEMORIAL PK 6/9/2		EASTON, MA	
n	Depart Impo		21. Signature of Funeral Service Licensee  John R. MERCERON  21. Signature of Funeral Service Licensee	2. Name and Address of Facility ELLOWS,HELFENBEIN 20 SOUTH HARRISON	& NEWNA	M FUNERAL	HOME, P.A. 21601
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate
ma	Physician		Immediate Cause (Final disease or condition PNCU mon I	A			Interval Between
d	, Medical Examiner		resulting in death)  Due to (or as a consequence of);				79
		ner	Sequentially list conditions, life my, leading to humadiate cause. Enter Underlying Cause (Disease or limitary)				
	uted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events c.				
	e exection and an arrial-tr	al Ex	resulting in death) Last Due to (or as a consequence of):				
8	icate be executed physician and s the burial-transit	edical	d				
8	eath certific attending p		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Date of deli	
200	death e atter	Physician/M	in the past 12 months?  1 Yes 2 4 Pregnant at time of death 5 [	Ectopic pregnancy Other (specify)		23d. Date of deliver Month	Day Year
5	es that the dec signed by the a f be detached t	Phy	9 Unknown				
ŗ,	res tha signed	d by	Part II. Other significant conditions contributing to death but not resulting in the	A 4 Pe Strok		cco use contribute to	the cause of death?
olds,	require been signal	Completed	Breast Cancer		24a, Was an		opsy findings available
מַ	The law cate has page 2 :	omo		-11-,	autopsy performe	prior to co	ompletion of cause of
5	i <b>cian</b> : The certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check	1 Tes 2 only one)	X No 1 Yes	2 1 10
5	Physician: Tr this certifica	욘	1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	nt 3 DOA Other:	ne 5 🗆 Residenc	e 6 Other (Specif	v)
5	ding F h. After i funera	ate	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury	work?	8d. Describe how	injury occurred	
2 .	Atten	Certificate:	2	M 1 Yes 2 No	8f Location (Stree	at and Number or Rura	I Route Number
2	tal or rs afte al Dire		building, etc. (Specify)	,	City or Town, S		rriotte rvampei,
	To the Nospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medica	29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death	tigation, in my opinion, death occurred at t	he time date and r	lace, and due to the ca	use(s) and manner stated
;	ithin 2 orthe omple		only one) 3 Certifying Nurse Practioner. To the best of my knowledge, a 29b. Signature and the of certifier	death occurred at the time, date and place	, and due to the ca	use(s) and manner as s	tated.
	F S F Ö		) / con a //en D, O.	H 476	) 29d	Date signed (Month,	Day, rear)
	RS		30. Name and address of person who completed cause of death (Item 23a) (Type, F	rint)	1/	1	
	10		1 Date flood About Day Your	100 DC	alle	ST (2	mbridge
	State Registra	~	31. Date filed (Month, Day, Year)  JUN 0 7 2012  32. Registrar's Signature	W			Ť

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ 10:20 June 9. Mozelle Lane Dorothy Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Country) AR Days Months Hours Jan. 31, <sup>Ye</sup>1942 213-38-4746 70 Director 1 □ M 2 🛣 F Usual Residence of Deced fshow 10d. Inside City Limits 10c. City, Town or Location 10a. State at . Page 1 and 2 should be filed within 72 hours after death with the Maryland Funeral Director notified 1 Yes 2 No 28a-f Silver Spring MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ь pe 23a 20906 **USA** 12206 Dewey Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Yes 2 X No 14. Race - American Indian 11. Marital Status Black, White, etc. "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: White 3 Widowed 4 X Divorced Completed ar than "he. "he Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working (Specify only highest grade completed) Bureau of Labor Statisticslife. DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Form Designer other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r and Mental I ၉ Violet Mozelle Baugh Eugene Herbert Ferguson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jaclyn Costello/Daughter Silver Spring, MD 27 12206 Dewey Road. item 20a. Method of Disposition 20b Place of Disposition (Name of June 15, 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2012 <u>Glen Burnie. MD</u> Crematory 21. Signature of Funeral Service Lie Coller Fundera TFSErvices, P.A. 4110 Aspen Hill Road, #100, Rockville, MD 20853 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Interval Between Onset and Death Immediate Cause (Final Physician/ Disseminated Intravascular Coagulation disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Poly-Microbial Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Chemotherapy-Induced Pancytopenia physician and s the burial-trans Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Day for in the past 12 months? Month Year Pregnant at time of death 2 XNo 1 Yes 2 L 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. det 23e. Did tobacco use contribute to the cause of death? Be Completed by Lung Cancer, Chronic Obstructive Pulmonary Disease, 1 Yes 2 No 3 XProbably 4 Unknown neac 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Superior Vena Cava Syndrome autopsy has certificate has lirector, page 2 performed Yes 2 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: 2XXNo ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 🛚 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident neral Director: A Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) D64100 June 12, 2012 O. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Smitha Bhikkaji, MD 1500 Forest Glen Road, Silver Spring, MD 20910

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Y

15

egistrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ ores 12 A Medical 4b. Ow, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** MARYS This 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) Country 217-60-5788 **Director** 1 🗆 M 2 🌠 F 28-1950 61 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland **Funeral Director** notified 28a-f 1 Yes 2 No Mills Great Maryland 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? ō ms 23a or must be n 20704 20634 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. by 1 Never Married 2 Married Yes 2 No ŏ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 Y No Specify Specify: "natural" Completed 3 Widowed 4 Divorced Black Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene. item 27 is marked other that other traumatic event, the N Cook Services 12 Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Morgan dohn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Department of Health ar Important: If item 27 is any injury or other trau once, Mora of Health 39 28 15A 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location -City or Town, State Date X Burial 2 ☐ Cremation 3 ☐ Removal from State crematory or other place, MArKs 4. M. C Donation 5 Other (Specify) uneral Service License 20608 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Oiset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, Examine Due to or as a consequence of If any leading to insteed cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Day Month Year Pregnant at time of death should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 nas certificate | Yes 2 No Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 🗆 No Other: 4 Nursing Home ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 🗌 this funeral ( 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completely filled in by the funera Natural 5 Pending work? 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signatur nd title of certifie 29d. Date signed (Month, Day, Year) 206 SO of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

legistrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend#20bperfuneralhome6/15 Pertinate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:10 PM June William Fleming McDonald Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Modica lata enter La 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 95 216-05-8027 1**X**□M 2 □ F January 20. 1917 Scotland Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 Yes 2 No Marvland | Charles Waldorf ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 70 Village Street 20602 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever III 0.0.

Armed Forces?

1 X Yes 2 No U S

If Yes, Give Army

Year or Dates. 41-45 the Medical Examiner Black, White, etc. ö ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Completed 3 X Widowed 4 Divorced Specify. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene.

is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Standard Oil 12th. event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew M. McDonald injury or other traumatic Margaret S. Fleming 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. Rita Wood/Niece 539 Briar Wood Drive, Carson City, Nevada 89701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, prematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hill Cemetery June 15, 2012 Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home MO1164 3035 Old Washington Rd. Waldorf, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final HYPERTENSIVE Physician/ HENRY disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions, if any leading to him did to cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Disk to for as a consequence off burial-transit and Due to (or as a consequence of): physician Physician/Medical certificate be Box 68760 the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day signed by the at Id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? certificate 2 1 No or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No 2 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 142509 6/12 30. Name and address of person pleted cause of death (Item 23a) (Type, Print) SMITH DLDLINE CENTE \$100 WARDORD MP 20602 MEIND EZT MD 12020 31. Date filed (Month JUN 15 2012 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle | Last) 2. Date of Death Physician/ Day Month Carole E. McKenzie Medical June 8 2012 12:03 P 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Larkin Chase Nursing Home Bowie Social Security Number 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min. **Director** 577 62 3095 1 □ M 2 🗓 F 63 Dec 3, 1948 Maryland Usual Residence of Decede show with the Maryland at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits rector notified 28a-f Prince George's Maryland Upper Marlboro 1 Yes 2 X No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 12100 Fenno Road 20772 United States ural", or items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates Page 1 and 2 should be filed within 72 hours after 2 **X**No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 'natural" Completed 3 U Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) the Prince George County Schools Secretary event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ၉ John H. McKenzie Emily E. Coombs traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traconce. 9607 Croom Road, Upper Marlboro, MD 20772 Jill Primrose (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) June 13,2012 Mount Carmel Cemetery Upper Marlboro, MD Signa ve of For 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MO Ferry Road, Clinton. MD 20735 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sk, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death late Cause (Final Ph sician/ Cardioves iratory Collage disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Ovarian Cancer Months Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examir Sacral Decubitus burial-tran Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Pregnant at time of death 1 Yes 2 L 9 Unknown Yes 2 X No pec the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by be Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autop performed 2X No death? certificate 1 ☐ Yes 2X No Yes To the Hospital or Attending Physician: 25. Was case referred to medica funeral director Be 26. Place of Death (Check only one) 2 XNo Other: 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 XX Nursing Home 5 Residence 6 Other (Specify, Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XXNatural 5 Pending 1 🗌 Yes 2  $\square$  No hours after death 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D Medical 1 XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0058976 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Suite 200, Glenn Dale, MD 20769

Nima Calaf, M.D. 12150 Annapolis Road,

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2012 Mary Edna Morgan Physician/ June 9 Medical Facility Name (if not institution, give street and number)
St. Mary's Nursing Home 4b. City, Town, or Location of Death 4c, County of Death St. Mary s **Examiner** Leonardtown If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign ial Security Number 8 34 66 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** May 5, 1935 6608 Months Days Hours 77 1 □ M 2 🔀 F Director MD 28a-f show 10c. City, Town or Location Leonardtown 10d Inside City Limits 10b. County Examiner must be notified at Director Mary's MD 1X Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 21585 Peabody St. 10f. Zip Code 20650 or items 23a or Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No
If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify. 72 hours after Maryland 21215-0036 Specify: Black and Mental Hygiene. is marked other than "natural", 3 Widowed 4 Noivorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Private Elementary/Secondary (0-12) College (1-4 or 5+) Beauticián Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Gough Mary Gordan 19a. Informant's Name/Relationship (Type, Print)
Sharon Coulter 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7453 Shady Glen Terrace Capitol Heights
MD, 20743 Daughter permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Beltsville, MD 20b. Place of Disposition (Name of 6/16/12 cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral Home 2294 Old Washington Rd. Waldorf, MD 20601 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Immediate Cause (Final lostolic Onset and Death Concer Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and and -tran Due to (or as a consequence of): resulting in death) Last burialphysician s the burial by Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ for Month Dav Year Pregnant at time of death ed by the a g 🗌 Unknown 9 Unknown P.O. signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Hospital Other:  $_4$ X Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? nours after death.

neral Director: After the filled in by the funera 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 234198 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Federle, M.D.24035 Three Notch Rd.Hollywood, MD 20636 David M. 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alma Pauline Matheson JUNE 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month. Day, Year) Hours Country) Director 214-34-6971 1 □ M 2 🗓 F 97 Yrs Usual Residence of Decede Feb. 25, 1915 Pennsylvania 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 109 Della Lane 21713 U.S.A. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ρ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give 3 X Widowed 4 Divorced White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than " Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Medical Technologist Medical Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oliver\_James Peter Laura Eva Albright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Janet E. Luther/Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i once. 1483 Saucon Meadow Court, Bethlehem, PA 18015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Parklawn Mem. Park</u> 06/23/12 | Rockville, Maryland 22. Name and Address of Facility of Funeral Service Licenses Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike, Boonsboro, Marvland 21713 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line 20nget and Death Immediate Cause (Final ardwarmo Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as physician and the burial-transit APPROVED BY MEDICAL EXAMINER Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical death certificate be CERTIFIC Records, P.O. Box 68760 as t s, outcome of pregnancy
Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: use 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Month Day Year 1 ☐ Yes 2 to 9 ☐ Unknown detached signed by Part II. Other significant condition ut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has page performed' 2 🗌 No 1 Tes Yes 2 N **Division of Vital** 25. Was case referred to medical Hospital or Attending Physician: funeral director. Be 26. Place of Death (Check only one) examiner?
1 X Yes Hospital Other: ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 5 Pending fd 10:40AM subject fell 2 X Accident fd 6-13-12 1 Yes 2 X No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 109 Della Ln. 4 Homicide determined Driveway Boonsboro,MD. 24 hours a Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and titl 244946 30. Name and andress of person wh Boonstore MD 21713 nins Rd State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 0415 AM Miller 2012 mes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ltos vital a Memoral East Talbo DM 5. Social Security Number If Under 24 Hrs 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 04/04/1931 81 WASHINGTON, DC 215-26-6510 Director 1 🗶 M 2 🗆 F 28a-f shov 10c. City, Town or Location notified at 10a. State 10b. County 10d. Inside City Limits Director 1 X Yes 2 No MD TALBOT TRAPPE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be items 23a Funeral 3856 SEYMOUR DR. 21673 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, the Medical Examiner Armed Forces?

1 X Yes 2 No Black, White, etc ò 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 Specify: WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed, and Mental Hygiene. Elementary/Secondary (0-12) 12 College (1-4 or 5+) **5+** HOSPITAL ADMINISTRATOR HEALTHCARE other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည GEORGE J. MILLER ELEANOR M. DUTTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. RUTH A. MILLER/SPOUSE 3856 SEYMOUR DR. TRAPPE, MD 21673 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of CHES) AP EAK Fron CREMATE) ON 1  $\square$  Burial 2  $\overleftarrow{\mathbf{X}}$  Cremation 3  $\square$  Removal from State D6/10/2012 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) CENTER 21. Signature of Funeral Service Licenses PEDEOWS Addred FENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 MERC E RON Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOMYOPATHY Ph\_sician/ ISCHEMIC disease or condition Medical resulting in death) Examiner ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events RENAL DISEASE STAGE The law requires that the death certificate be executed burial-trar Due to (or as a consequence resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy rmed? 2 No within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 🗌 Yes 1 Yes To the Hospital or Attending Physician: funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner?

1 Yes 2 👿 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0059487 6-9-12 NS 30-Name and degree of personny ho completed cause of death (Item 23a) (Type, Print)

6+VA

SEOTER

State

219 S. WASHINGTON ST. EASTON, MD21601

ed (Month, Day, Year)
JUN 1 1 2012

Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Matthew Jarrett 2347 Mason Und Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Memorial Easton lalbot Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Days Min. Country) Director 1 🔀 M 2 🗆 F 222-70-0155 42 08/02/1969 DE. 10a, State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD. Caroline Denton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21629 8207 Cicle Court U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 Married ģ 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Merian injury or other traumatic event, the Merians injury or other traumatic event injury or other tra Elementary/Secondary (0-12) College (1-4 or 5+) - 0 -I.T.C. Education 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Louise Blackwell Richard L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
14 Freshwater La. Hilton Head S.C. 29928 Richard L. Mason/ Father 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Crem. of Delmarva 06/09/12 Delmar, DE. 21. Signature of Funeral Service Licensee Hurriey Address Ostrowski Funeral Home P.A. M. Ostrowski C.F.S.A Box 518 St. Michaels, MD. p.o 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SYNDROME EISEN MENGER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine PULMONARY HYPERTENSION physician and s the burial-transit SEVERE Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?/ Yes 2 No 2 🗆 No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 🖭 No ၉ 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28c. Injury at work? 1 \(\sum Yes\) 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🔲 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by determined 24 hours a Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

**RS** 5

JOHN BUTSIS

Botsis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

219

Matther

D0059487

Washington St. Easton, Md.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month 1112 DORIS S. MARTH 2012 06 06 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death TALBOT MEMORIAL itospimi EASTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 0172671933 NEW YORK Director 220-28-2355 79 1 🗆 M 2 🗓 F parmit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mantal Hygiene. Importent: If item 27 is marked other than "natural", or itema 23a or 28a-f shor any injury or other traumatic event, the Madical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD CAROLINE PRESTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3676 POPLAR NECK RD. 21655 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) CAROLINE BOARD OF Elementary/Secondary (0-12) College (1-4 or 5+) EDUCATION BUS DRIVER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ PAULINE GYSLER RICHARD SUMP 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2410 EDGEHILL RD. OTTAWA HILLS, OH 43615 LETITIA D. MARTH/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of ST centerary Crematory of minerals) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State CHURCH CEMETERY 06/13/2012 CORDOVA, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee BELLOWS Add HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 JOHN R. MERCERO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial Immediate Cause (Final Onset and Death Physician/ HCHTE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death cartificate be exacuted the attending physician and thad for usa as tha burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day paga 2 should be datachad 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by yper lipidenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown baen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Mellitus type Aftar this certificata 2 1 No 1 Yes 2 No Yes within 24 hours aftar death.

To the Funeral Director: Aftar this certifica completaly filled in by tha funeral diractor, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. The Certifying Prysician: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

725 10

Registrar

31. Date filed (Month, Day, Year)
JUN 1 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Washington Street 32 Registrar's Signatu

D0056969

Easton, Maryland

Salvatore Verteramo, MD

29d. Date signed (Month, Day, Year)

June 7, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JUNE PAMELA ANNE MACKLEY 10 2012 8:26 A M Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 219-66-2763 1 🗌 M 2 🗶 F 56 January 21, 1956 West Virginia Usual Residence of Deced 28a-f show the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Sabillasville 1 🗌 Yes 2 🕱 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17663 Old Sabillasville Road 21780 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify White Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Certified Nursing Assistant Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ Charles Anthony Rodig traumatic Nancy Jane Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra James Mackley / Husband 17663 Old Sabillasville Road, Sabillasville, Maryland 21780 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Mount Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) June 14, 2012 Frederick, Maryland Signature of Faneral er e Lican 22. Name and Address of Facility **Keeney & Basford P.A. Funeral Home** 106 East Church Street, Frederick, Maryland 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Of set and Death Immediate Cause (Final Physician/ Heliatic disease or condition resulting in death) Medical Examiner months Sequentially list conditions, Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and -trar Due to (or as a consequence of resulting in death) Last physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the use as i attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 9 Unknown g Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Ofath 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? this certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 1 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 X Natural 5 - Pending injury 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 🕩 ertifier 29d. Date signed (Month, Day, Year) W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 Marius NE.

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 9:44 P M June Kathleen Virginia Newcomer Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington Hagerstown Somerford Assisted Living If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Age (In yrs. last birthday) Hours Min. (Month, Day, Year) Director 219-66-1984 1 □ M 2 🛛 F June 12, 1916 Maryland 96 Usual Residence of Decedent at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Tes 2 X No Maryland\_ Washington Boonsboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items 23a iury or other traumatic event, the Medical Examiner must b 21713 U.S.A. 19826 Benevola Newcomer Road 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. 3 X Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sadie Estelle Cline Harry Mumma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19718 Benevola Newcomer Rd. Boonsboro, MD 21713 Ruann N. George/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 X Burial 2 Cremation 3 Removal from State Benevola Church Cem. | 06/22/2012 | Boonsboro, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA Signature of Funeral Service 7606 Old National Pike Boonsboro, MD 21713 Enter the disease, or comport or heart failure. List only on Approximate Interval Between Onset and Death ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final h sician disease or condition Medical resulting in death) Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Day Month Year Pregnant at time of death been signed by the a should be detached f Yes 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of Was an page 2 certificate has autopsy perform death? 1 Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other 은 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending after death. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide completely filled in by determined City or Town, State) 24 hours a Funeral L Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 1 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D32518 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND 29D, PER MD G929 7/31/12 TRT State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year Physician/ 16 6:15 PM Sandra Lee Needy June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 449 Guilford Ave. Washington County Hagerstown 8. Date of Birth Nov. 26,1943 Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 213-42-1577 **Director** 1 □ M 2 🛛 F 68 Vermont Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Maryland Washington County Hagerstown 10e, Street and Number 10f. Zin Code 10g. Citizen of What Country? ò Funeral with 1 'natural", or items 23a 449 Guilford Ave. 21740 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent \_\_\_\_ Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify If Yes. Give Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed. other than Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank O. Davidson Kathleen L. Dewey permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David F. Needy, Jr.-husband 449 Guilford Ave. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6-19-2012 4 Donation 5 Other (Specify) Greenlawn Mem. Park Williamsport, MD Signature of Funeral Service 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or or molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Das Medical Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or, Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery es, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) in the past 12 months? Month Dav Year the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 after death.

Director; After this certificate 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, JUNE 18, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) age rotown, WI egistrar's Signato State 1'8 **2012** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20684 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 06710/2012 5:05 P HAZEL ANNA NATALE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CAROLINE ENVOY OF DENTON HEALTHCARE CENTER DENTON 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours Director 1 □ M 2 🛛 F 85 207-16-2581 03/24/1927 MARYLAND Usual Residence of Deceder or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland be notified at by Funeral Director 1 X Yes 2 No CAROLINE DENTON MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a 21629 USA 420 COLONIAL DR. items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: Specify. "natural", 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4 or 5+) ADMINISTRATOR US NAVY/JUSTICE DEPT. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ ANITA D. EBERHARD CLARENCE W. WOOTERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13016 OAK RD. GREENWOOD, DE 19950 PATRICIA A. BAKER/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 06/16/2012 CORDOVA, MD FAIRVIEW CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) Sign / FELTEOWS drene FERENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little Univerlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 phy as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ HTPERCHOUSTERNLEMIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident 124 hours after death e Funeral Director: / pletely filled in by the f Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🞽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

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only one 29b. Signature and

30. Name and address of person who completed cause of

JUN 1 3 2012

BLOOMINGDALE

death (Item 23a) (Type, Print)

Registra

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:55А. м Physician/ Mohammad Nematollahy  $18,^{\text{Day}}$ Jumeth 201<sup>Y</sup>2<sup>ar</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Bethesda Montgomery Suburban Hospital Social Security Number If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Aug. 16, 1920 219-37-4602 1 M 2 - F Iran **Director** 91 or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director Bethesda Maryland Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö ms 23a or must be r by Funeral 5812 Lone Oak Drive 20814 United States items Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nopermit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiners once. 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Superintendent Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Hasan Nematollahy Roghieh-Banoo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5812 Lone Oak Drive Bethesda, Maryland 20814 Zahra Nematollahi -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place
National Memorial Park X Burial 2 Cremation 3 Removal from State 6/22/2012 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonald V: Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Septic Shock disease or condition resulting in death) Medical Nematollahy, Mohamme Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Pneumonia Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Congestive Heart Failure; Acute Renal Failure; 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No Acute Respiratory Failure; Urosepsis; Parkinson's 24a. Was an autopsy Yes 2 AN Disease 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: မှ 1 ☐ Yes 2 X No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending WOFK? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month. Day, Year) D17656 Maelm June 18, 2012 M.D m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tipaporn Woodward, M.D. 7830 Old Georgetown Road, #C15 Bethesda, Maryland 20814 31. Date filed (Month, Day, Year) 22. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

JUN 28 2012

			1 - For State Registrar	e of Maryland		artment of He tificate of D			ene .No. 2012	20686		
	Physici /Medio		Decedent's Name (First, Middle, Last)	Evette Ba	abs Na	amm		2. Date of Death Month June 22	Day Year , 2012	3. Time of Death 9:40 A		
*	Examin		4a. Facility Name (If not institution, give street and	d number)		4b. City, Town, or L	ocation of Death		4c. County of Death			
-			Golden Living Center  5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)		erstown If Under 24 Hrs.	8. Date of Birth	Washin			
	Funeral Director		214-48-8755 1□ M 2X□		Yrs.		Hours Min.	(Month, Day, Ye		place (State or Foreign		
	pu ,		Usual Residence of Decedent					ren. 21,		ington DC		
	arylar show	'n	10a. State 10b. County  Maryland Washington	10c. City,	Town or Lo		t		1	10d. Inside City Limits 1		
	the M 28a-f	Director	10e. Street and Number			Hager	stown	100	. Citizen of What Cour			
	3a or		56 Wayside Ave.			217	40	log	U.S.A.	nuy r		
	death	Funerai	11. Marital Status 12. Was	Decedent Ever in U.S.	13. V	Vas Decedent of Hisp Yes, specify Cuban,	panic Origin? (Spe	ecify Yes or No-				
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If health and Mental Hygiene, Item 27 is marked other then "naturel", or items 23s or 28s-f show other traumatic event, the Madical Examinar mantice rollined at	by	1 Never Married 2 Married 1 □ Y	d Forces? es 2 XNo , Give or Dates:		-	Mexican, Puerto Specify:	Rican, etc.)	Specify: WI	etc. hite		
ה ה	72 ho	Completed	15. Decedent's Education (Specify onfy highest grade comple	ted		ent's Usual Occupation		16	b. Kind of Business/In	dustry		
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7	iled w Hygier Ther ti	Co	12 17. Father's Name (First, Middle, Last)			Homemake:		(film )	Home			
<u>a</u>	d be f antal h red of	Be C	Morris Pincus			11		(First, Middle, Mai	iden Sumame)			
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ກົ	of Her		20a. Method of Disposition		e of Dispos	sition (Name of atory or other place)		Date 20d	c. Location - City or To			
	Page ment can ant: if ury or	П	1 ☐ Burial 2 <b>图</b> Cremation 3 ☐ Removal fi 4 ☐ Donation 5 ☐ Other (Specify)	om State	-	g Cremato		26, 012 S	mithsburg,	Maryland		
	permit. Pages 1 an Depertment of Heal Important: if item 2 any injury or other 9052.		21. Signature of Funeral Service Licensee	M014		Name and Address	of Facility	J.L. Dav	ris Funeral			
			23a. Part1. Enter the disease, or complications the	nat caused the death.					rg, Maryla	Approximate		
ť	Physician /Medical		shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line. Letarta Cic o to (or as a conseque)	L	mg Co	mer			Interval Between Onset and Death		
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	<b>d</b>		30. Name an address of person o completed of	eause of death (Item 2:	Sa) (Type, F	Print)  A	no Hac	Para Louise	6/25/12 MD 2	17117		
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Registrar DHMH 17 Rev 1/2001

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		For State		State of I	Marylan			Health and	Mental Hy	giene 2	012	20687	
		Registrar  1. Decedent's Name (First	t. Middle. Last)			Cer	tificate of	Death	2. Date of De	Reg. No.	011	3. Time of Death	
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Examine		4a. Facility Name (if not in: RESIDENCE .					4b. City, Town, o	or Location of Deatl	h	1	nty of Death	)DCEC	
Funeral		5. Social Security Number			Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs.					
Director		578-84-4357 Usual Residence of Dec		M 2 🕱 F	53	Yrs.	Months Days	Hours Will.	, , , , , , , , , , , , , , , , , , , ,			NGION, D.C.	
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with the 23a cast be	Funeral Director	5547 LANIER	AVENUE				20746			UNITED STATES			
death r items iner m		11. Marital Status		2. Was Deceder Armed Force	s?	6. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	oecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 Never Married 2		1 Yes 2 If Yes, Give Year or Dates		1	☐ Yes 2 🗓 No	Specify:		Specify: BLACK			
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permi Depar Impo any ir		21. Signature of Funeral S	THORNTO	ON JOHNS	SON MO	0583 34	HORNTON 439 LIVI	FUNERAL H NGSTON RO	IOME, P. DAD, IND	A. TAN HEA	D. MAI	RYLAND 20640	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the but the funeral director.	Physician/Medic	IF FEMALE: 23b. Was decedent pregn in the past 12 month: 1	iaiii	c. If yes, outcor 1  Live Birt 4  Pregnan 9  Unknow	h 2 🗀 Feta it at time of c	l death 3	Ectopic pregnan	ісу			Date of delive	ery Day Year	
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ial or Attendi s after death al Director: A ed in by the f		4  Homicide	determined		Injury - At ho etc. <i>(Specify)</i>		et, factory, office		28f. Location (S City or Tov		nber or Rural	Route Number,	
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check 2X M	edical Examine	r: On the basis of	f examination	and/or investi	igation, in my opini	ne, date and place, ion, death occurred the time, date and p	at the time, date a	and place, and	due to the cau	use(s) and manner stated.	
To within		29b. Signature and title of	certifier	Afti	erte	70	29c. Licens			JUNE 1			
pa-4		30. Name and address of											
State		SALVADOR SYL 31. Date filed (Month, Day,	(Vear)		255 RC strar's Signat	CKVILI	E PIKE,	SUITE 12	5, ROCKY	ILLE.	MARYLA	ND 20850	
Registra	-	JU	N 1 3 201	12 Den	wa,	D. A	ave						

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last)
Clifford Kirwin Parkinson, Jr. **Physician** 2:11 PM 12 June 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 26308 Mt. Vernon Road Princess Anne Somerset 8. Date of Birth (Month, Day, Year) 5. Social Security Number if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday) **Funeral** 1**√**M 2□F Days Hours 214-34-8676 May 12, 1937 Director 75 Maryland Usual Residence of Decedent a or 28a-f show t be notified at 10d. Inside City Limits 10c. City. Town or Location 10b. County 1 □Yes 2 No Director MD. Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? with 26308 Mt. Vernon Road "natural", or Items 23a 21853 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1955 1074es 2 □ No If Yes, Give 1959 Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) " If item 27 is marked other than "or other traumatic event. The " Elementary/Secondary (0-12) College (1-4or 5+) Corrections Correctional Officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clifford K. Parkinson, Sr. Elizabeth Jones Parkinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Parkinson Wife 26308 Mt. Vernon Rd., Princess Anne, MD. 21853 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite N Burial 2 ☐ Cremation 3 ☐ Removal from State Asbury Un. Meth. Ceme: 06/16/2012 4 □ Donation 5 □ Other (Specify) injury Mt. Vernon, MD. 22. Name and Address of Facility Hinman Funeral Home 21. Signature of Funeral Service Licensee M00295 11673 Somerset Ave., Princess Anne, MD. 21853 Enter the disease, or complications that caused the death. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, diate Cause (Final se or condition **Physician** dist ase or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Each of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed aftending physiclan and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No O. been signed by the should be detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autonsy performed? 1□ Yes 2☑ No certificate this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation To the Hospina. ... within 24 hours after death.
To the Funeral Director. Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division or Vital Records, P. Hospital or Attending Physician:

State Registrar 29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person w

lennen Rd Princess Anne

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Frances RECHER 8:06 A M JUNE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Meritus Medical Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** Hours Director 215-26-1471 1 M 2 X F 82 Yrs. Nov. 29,1929 Pennsylvania 10c. City, Town or Location death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Maryland Washington Williamsport 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a Examiner must be Funeral 16505 Virginia Avenue 21795 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 X Never Married 2 Married Completed by 1 Yes : 2 X No Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) teacher Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Josiah Recher Earl Mabel Virginia Wagner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Post Office Box 235, Smithsburg, Maryland 21783 Gary L. Recher -nephew Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Marks Lutheran
Cemetery 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State June 19 2012 4 ☐ Donation 5 ☐ Other (Specify) Wolfsville, Maryland Signature of Juneral Service Licensee 22. Name and Address of Facility Minnich Funeral Home rolid DIG 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician) Medical resulting in death) Due to (or as a consequence of Examiner Sacuar tielly liet condition Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and attending physician Physician/Medical д С Р.О. Вох 68760 If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy

5 ☐ Other (specify) \_\_\_\_ IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Month Day Year signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' after death.

Director: After this certificate ☐ Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗆 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year) 6/15/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ·nko Jose 00 11/10 0 31. Date filed (Month, Par.) 1 9 Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June Day 2012 14, 4:45 PM David Paul Russell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Homewood of Williamsport Williamsport Washington Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** nte oi Nonth, Pay, Days 1 🗶 M 2 🗆 F Months <sup>Year</sup> 1922 90 Maryland Director 215-14-1427 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits notified at Director 28a-f 1 Yes 2 X No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 17819 Garden View Road 21740 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced ntal Hygiene. ed other than "natura event, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Account Auditor Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H If item 27 is marked ot r other traumatic even permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is martany injury or other? ည Frank Keifer Russell Lena Mary Winters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia J. Russell/Wife 17819 Garden View Rd., Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery ! 6/18/2012 Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Rest Haven Funeral Chapel 22. Name and Address of Facility 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory amendock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence on Exami physician and the burial-transil requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day Yea n signed by the a ld be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ within 24 hours after death.

To the Funeral Director. After this certificate has been signs completed filled in by the funeral director, page 2 should be a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an かくの 1 Yes 2 No or Attending Physician; Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 X No 1 Tyes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 26506 15 2012 (Type, Print) erson who completed cause of death (Item 23a) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State of Maryla AACO HEALTH DEPT. CMH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month UCILLE June 2012 11:50 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel 186 12th Street Pasadena Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 85 **Director** 398-20-7219 1 □ M 2 🔀 F Aug. 21,1926 Wisconsin or 28a-f show notified at the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe Funeral ian "natural", or items 23a Medical Examiner must b 12th Street 21122 USA 186 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Yes 2 XNo δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker **Home** 12 nt of Health and Mental Hygist of Health and Mental Hygist of the other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Frieda Walter George Schutten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 186 12th Street Pasadena, MD 21122 Betsy Taylor / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State June Date 12, 1 Burial 2 XCremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC; Baltimore, MD 2012 mature of Funeral Service Livensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park, MD 21146 2 a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immedia & Cause (Final disease or condition resulting in death) Physician. Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical certificate be P.O. Box 68760 F FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORDNARY ARTERY Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 HYPERCHOLESTEROLE MIA performed? Yes 2 4 certificate 1 Yes 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? n 24 hours after ceau... he Funeral Director: After this ce noletely filled in by the funeral dire Hospital 2 🎏 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 K Residence + 100 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Suicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sta

Registrar

DHMH 17 Rev 06-2011

KIM, MD

1412 N. CRAIN HWY GA GLEN BURNIE MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Norma Jeanne STEIGMAN <sup>D</sup>2012 7:05pm June 17, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death NMS Health Care Hagerstown Washington Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) n. 16,1933 Hours 1 🗆 M 2 🕱 F 220-28-7857 79 Jan. **Director** Maryland Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 11605 Peacock Trail 21742 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married 2 K No Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify. white Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) 12College (1-4 or 5+) operator telephone company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hughie Mowbray Helen Stouffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 i Robert W. Steigman - Husband 11605 Peacock Trail, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot 1X Burial 2 ☐ Cremation 3 ☐ Removal from State June 2012 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 110 disease or condition Medical resulting in death) Due to (or # a consequence of) **Examiner** Mem Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examin Hospital or Attending Physician: The law requires that the death certificate be executed cment and-tran Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. as been signed 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ €nknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy page perform After this certificate I 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital မြ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred T Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) For 118 D060390 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FARID

NV PS NED FARID

State

Registrar

31. Date filed (Month, Day, Year)

JUNIO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Myrle Geraldine Spickler June 2012 6:15 P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Washington County Hagerstown 18014 Putter Dr. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 214-09-1416 Maryland 100 Jan. 3, Director 1 🗆 M 2 💢 F 1012 Usual Residence of Decedent 28a-f show 10d. Inside City Limits and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor aumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No Hagerstown Maryland Washington County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 U.S.A. 18014 Putter Dr. · death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Truck Mfg. Co. Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frisby T. Spickler Edythe Mong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau once. 410 Bashore Dr. Martinsburg, WV 25404 Beth Nesmith-great-niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Paul's Cemetery 6-18-2012 4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, MD 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Lice 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Drabaw Physician/ disease or condition Medical resulting in death) ue to (or as a consequence **Examiner** Sequentially list conditions Due to (or as a consequence of, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events use as the burial-transit Due to (or as a consequence of) resulting in death) Last signed by the attending physician be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes No Day Pregnant at time of death 1 Yes 2 Unknown 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has b autopsy 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 \( \to \) Nursing Home 3 \( \frac{1}{12} \) Residence 6 \( \to \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitions: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis
Certifying Nurse Practitions: To 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sylvary Avenue Hagesitam no 21742 wo 31. Date filed (Monti

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Cloid Russell Smith. 2012 · 10 Medical 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Washington 9. Birthplace (State or Foreign **Honewood** 8. Date of Birth rs. last birthday **Funeral** Hours Min 1 QM 2 Q 11-28-1924 Washinton, DC 88 Director Usual Residence of Deceden 28a-f show City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Washington Williamsport ıral", or items 23a or 28a-f s I Examiner must be notified Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 16505 Virginia Ave Apt. A318 21795-1367 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. þ 1 Never Married 2 Married hours after Maryland 21215-0036 1 Yes 2 No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 permit. Page 1 and 2 should be filed within 7: Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) <del>United airlines</del> Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cloid Russell Smith SR. Ethel Mcconchie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Tarkay Place, Martinsburg Wv 25403 Patricia Rutledge Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2x Cremation 3 Removal from State cemetery, crematory or other place, -16-2012 4 Donation 5 Other (Specify) Hagertown Md Hagerstown CRemator 22. Name and Address of Facility Simpature of Fu 917 Cemetery Rd. Rosedale Funeral Home Wv. 25404 Part/1. Enjer the disease, or complications the shock, or heart failure. List only one gause on a t enter the mode of dying, such as cardiac or respiratory arrest caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events and I-tran Due to (or as a consequence of): resulting in death) Last burialphysician the burial Physician/Medical that the death certificate be Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year Pregnant at time of death the P.O. þ Part II. Other significant conditions contributing to death but not resulting 23e. Did tobacco use contribute to the cause of death? signed I þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Winknown Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has page 2 death?
1 Yes 2 No FIBNICCHTE certificate 4TAIAL a case referred to medical Division of Vital 26. Place of Death (Check only one) Be Hospital: Other: 1 Tyes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4' Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after deau..

To the Funeral Director: After th funeral 27. Manner of Dath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Acciden injury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signat 29d. Date signed (Month, Day, Year) 30. Name

Registrar

DHMH 17 Rev 7/2009

State

inda A. Sweat		State of Marylan		i <b>delible</b> i artment c <i>tificate c</i>		and Mental F		jible. g. No. 201	12-20695
Physicia	n/	Registrar		-			2. Date of Deat	h	3. Time of Death
Medical Examin	er	Linda Ann Sweat  4a. Facility Name (if not institution, give street and numb	ner)		4b City Tow	n, or Location of Dea	June 10, 2	012 4c. County of	1406 nrs
0	N.,	Holiday Inn 5400 Holiday Drive Rm 264	,		Frederic			Frederick	
Funeral	П		Age (In yrs. la	• • •	If Under 1 Months	Year If Under 24H	<del></del>	1	Birthplace (State or Foreign
Director		216-78-5607 1 M 2 XF		54 Yı	rs.	Bayo Flooro IVII	May 11	, 1958	CountryMaryland
any	ŀ	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loca	ation				10d. Inside City Limits
and F show	5	Maryland Frederick	Wa	lkersv	ille				1 X Yes 2 No
r 28a-	Director	10e. Street and Number			10f. Zip Co		10	g. Citizen of Wha	-
with the	릵	2807 Raleigh Road  11. Marital Status   12. Was Deced	ent Ever in U.	S. 13. W		793 of Hispanic Origin? ( §	Specify Yes or No-	United 14. Race	States  - American Indian, Black,
death or item	uneral	1 Never Married 2 Married Armed Force	es? 2 X No	If	Yes, specify C	uban, Mexican, Puerl	o Rican, etc.)	White,	, etc.
s after rral", o	ð.	3 Widowed 4 X Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade or Dates)				No specify:	fundi dana	Specify: 16b. Kind of Bus	White
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212 ould be I Ments marke	To Be	19a. Informant's Name/Relationship (Type, Print )		19b. Maili	ng Address (	Street and Number or			ı, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	1	Odus W. Sweat/ Father							ryland 21774
Ore,		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from	State C	crematory or o		•	Date /1.0./2010		City or Town, State
Itim iit. Pagartment		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Sta						ck, Maryland
Depr.	1	TODD D. WYNN, CFSP PER	DVR	116	21 Onos	Funeral H	ike. Fre	derick.	Maryland 21702
Physician /Medical		23a. Part I. Enter the disease, or complications that caus failure. List only one cause on each line.	ed the death.	. Do not enter	the mode of d	ying, such as cardiac	or respiratory arre	est, shock, or hea	rt Approximate Interval Between Onset and Death
vaminer	L Ethanol Butainital and Divicodone Intovication								
	. '	Sequentially list conditions, b.		.,,					
	nine	if any, leading to immediate Due to (or as a cocause. Enter Underlying Cause	nsequence of	f):					
ed nsit	Examine	events resulting in death) Last Due to (or as a co	insequence of	f):					
execul an and al - tra		d.    UNPENDED   X AMENDED   X		00 10/	11/10		-		
760, cate be physical	Physician/Medical	UNPENDED X AMENDED 21 PER 23c. If yes, out	come of pregr	132 107 nancy	11/12	TRT		23d. Date of	delivery
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Box e death the atte	hysi	1 Yes 2 No 9 Unknown 9 death Unknown							
, P.O. Box 68760, res that the death certificate bo signed by the attending physics be detached for use as the bur	ρ	Part II. Other significant conditions contributing to do Cutting Wounds of Wrists	ath but not re	esulting in the	underlying ca	use given in Part I.	23e. Did to		oute to the cause of death?  Probably 4 Unknown
'ds, requires	Completed by	Catalog Woulder of Whote	<del></del>				24a. Was a		/ere autopsy findings available
ecor ne law i te has t ge 2 sh	du						autops perfor		rior to completion of cause of eath?  Yes 2 No
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Ing Affe	ion:	27. Manner of Death  1 Natural 5 Pending  28a. Date of FOUND:	ay,Year)	28b. Time of FOUND:	rinjury 280	. Injury at Work?  Yes 2 ✓ No		ow injury occurre sted drugs a	
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Diversal cours at the filled	Cert	4 Homicide determined (Specify)	Hotel Roon	n 264	_		or Town, Si 5400 Holiday I	Drive, Frederic	k, MD
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	29a. Certifier 1 Certifying Physician: To the best of one)  2 Medical Examiner: On the basis of each of the basis	examination ar						
To T vith	Med	29b. Signature and title of certifier	ed.			icense number			ed (Month, Day, Year)
		"////			C	D.C.M.E.		August 27,	2012
OCME	ļ	30. Name and address of person who completed cause Mary G. Ripple MD. Deputy Chief Me	•		0 W Baltin	nore Street Palt	imore MD 21	223	
Sta	te		strar's Signatu				miore, MD ZT		
Registr			une,	B. 19	arker				

Please Type or Printin Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 10, 2012 Walburga Marie Stelmaschuk 4:40 Рм Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick 1 Year | If Under 24 Hrs Davs | Hours | Min. Social Security Number 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 213-32-6434 **Director** 80 1 M 2 X F June 28, 1931 Czechoslovakia Yrs Usual Residence of Decede 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No Baltimore Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21225 622 Douglas Street within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Anne Arundel County Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the A once. Public Schools School Bus Aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Eisenkolb <u>ی</u> Anna Baumann Edwin Isenkolb 119b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9407 Glade Ave., Walkersville, MD 21793 19a. Informant's Name/Relationship (Type, Print) Rosemary Thompson / Daughter Date e 11, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)  $^{\rm June}_{\rm 2012}$ 1 Burial 2 X Cremation 3 Removal from State Resthaven Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licer Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one each line. Approximate Interval Between Onset and Death Immediate Cause Final Physicians Cardiomyopathy disease or conditi Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or Injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Day Year Month 5 Other (specify) the a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🎛 No has within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 K No ျှ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending 1 X Natural Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of 29c. License number 29d, Date signed (Month, Day, Year) June 11, 2012 D 0061410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

Gaffar Syed, M.D.

31. Date filed (Month, Day, Year)

JUN 1

32. Registrar's Signature

901 Toll House Ave., Frederick, MD 21701

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Examiner		,		EMORIAL HOSE	PITAL		4b. City, To			or Death		l l	. County			
Funeral	45	5. Social Security Nu 133-20-2	umber	6. Sex 7. A	ge (In yrs. I	ast birthday	) If Under 1		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th		9. Birt	hplace (State o	r Foreign
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene. Inmoortant: I fire az is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		400 N.		:h		10f. Zip Code 33431							SA	What Oo	and y:	
death items ner m		11. Marital Status		12. Was Decedent Armed Forces						ecify Yes or No- Rican, etc.) 14. Race - American Inc Black, White, etc.						
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Illed will Hygin other vent, t	3	17. Father's Name (F		,						e (First, Middle,		Surname	e)			
Mental Mental narked natic ev	2	John P.									umphrey					
2 shouth and the shou		19a. Informant's Na  Mary Lou		nip (Type, Print) chueler – wi	fe		iling Address (							state, <i>Zip</i> <b>3343</b>	_	
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Page ment c ant: If ury or		1 Marial 2 L 4 Donation		3 🗷 Removal from Stat Specify)	Hon	newood	rematory or oth l Cemet	erpiace ery	Θ)	6–13	-2012	Pit	tsbu	rgh,	Pennsy	/lvani
Depart Mport Mport any inj ance.		21. Signature of Fur	neral Service I	icensee	0		22. Name and	Addres	s of Facili	ty Sta	uffer l	une	ral	Home	mul and	21702
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n signed	3	Park	inson'	s Disease							1 🗆	Yes 2	! □ No	3 🗆 Pr	obably 4	Unknown
Physician: The law requires this certificate has been sig rral director, page 2 should b :: To Be Completed I				rillation							24a. Was		24b. 1	Were aut	opsy findings a	available ause of
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ig Phy ter this neral c		27. Manner of Death	5 Pendir	28a. Date of in	ury	28b. Time	of 28	c. Injury work	at		28d. Describe				<i>1y)</i>	
or Attending P after death. Director: After t lin by the funera		2 Accident 3 Suicide	Investi	gation			М	1 🗆	Yes 2	No					.5	
after date din by		4  Homicide	determ	28e. Place of In building, e			street, factory,	office			28f. Location ( City or To			er or Hur	al Route Numb	er,
In the Propriat or Attending Physician: The law within 24 hours after death.  To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2:  Medical Certificate: To Be Comp				Physician: To the best of taminer: On the basis of												nner stated.
ithin 24			☐ Certifying	Nurse Practitioner: To t			ge, death occur	red at th				the caus	e(s) and n	nanner a		
- 3 = 5		1-m	cheh	- Maine	MO		1		62	48	}	6	7	/20		
(K)		30. Name and addre	ess of person	who so upleted cause of	death (Iten	n 23a) (Type	7	rth	а Ј.	Pier	ce, MD				-	
State		31. Date filed (Monti		32. Regist	rar's Signa	iture ,	•		· ch,	<u> MO</u>					-	
Registrar			JUN 1	3 2012 Bens	can	A. 6	parke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Most Co 4:24 PM Physician/ 2012 Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death **Examiner** dimina Social Security Number 173-24-8346 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min (Month, Day, Year) 1 M 2 □ F Director S Yrs JAN 23, 1932 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10b. County 10c. City. Town or Location death with the Maryland Director items 23a or 28a-f s ner must be notified 1 X Yes 2 No Baltimore Maryland Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 United States 600 Light Street, Apartment 826 12. Was Decedent Ever in U.S. Armed Forces? 12/4/52
1 W Yes 2 No to ff Yes, Give Year or Dates. 9/23/54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Examiner Black, White, etc. þ 1 Never Married 2 X Married "natural", or Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed 9/23/54 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4 or 5+) Manufacturing Expediter other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ermit. Page 1 and 2 should be file er artment of Health and Mental I nr ortant: If item 27 is marked on injury or other traumatic eve 2 Anthony Joseph Salvato Mary Venti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Salvato/Wife 600 Light Street, Apt. 826, Baltimore, MD 21230 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date e 6 20c. Location - City or Town, State 1 🗆 Burial 2 🗓 Cremation 3 🗆 Removal from State June Delaware County Crematory 2012 Lansdowne, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signative of Funeral Service Licenses once. Der Imr any 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, it any leading to immediate cause. Enter Underlying Exami executed Cause (Disease or injury that initiated events and I-tran Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Month detached 9 Unknown the P.O. signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has page 2 within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manper of Death 28a 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 7058 10+1VA 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 410-332-9610 31. Date filed (Month, Day,

DHMH 17 Rev 06-2011

State

Registrar

32. Registrar's Signature

**JUN 06** 

## 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2012 **Stiles** Charlotte Cecelia Medical 4a. Facility Name (if not institution, give street and питьег) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin If Under 24 Hrs. . Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Days Months Hours Jan 7 2 31 222-18-5966 Usual Residence of Decede Director 1 🗆 M 2🗶 F 81 or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director New Castle DE New Castle 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 19720 US 802 West 10th Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【X No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner Black, White, et þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file h and Mental H 7 is marked o ပ္ Catherine Sullivan William Lawler injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) daughter/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau executrix 195 Old Baltimore Pike Newark, DE Deborah A. Phipps 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🕱 Burial 2 🗆 Cremation 3 🖎 Removal from State June 14 St. Peter's Cemetery 4 Donation 5 Other (Specify) New Castle, Delaware 22. Name and Address of Facility re of Funeral Service Licenses Gebhart Funeral Homes 12012 531 Delaware Street New Castle, DE 19720 Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician) meser disease or condition Medical resulting in death) Due to (or as a consequence of) D Examiner Sequentially list conditions, if any, leading to immediate cause. Effer Underlying Examine Due to (or as a consequence of) burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No 5 Other (specify) Month Pregnant at time of death P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performe Division of Vital 25. Was case referred to medica or Attending Physician: 26. Place of Death (Check only one) Tiles, charlotte Be Hospital: Other: 4 \( \sum \) Nursing Home 5 \( \sum \) Residence 6 \( \sum \) Other (Specify) 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical 29a. Certifier 1/🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29d. Date signed (Mpnth, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

**JUN 11** 

15

Registrar DHMH 17 Rev 06-2011

1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

20:15

Birthplace (State or Foreign Country)

New Castle, DE

white

10d. Inside City Limits

Interval Between Onset and Death

Day

2 🗌 No

1 Yes

Year

1 X Yes 2 No

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\Omega\) 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Freeman Carl Thibault 14<sup>ay</sup> 20T2 1:07 Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 74 Director 101-30-7131 1 XM 2 □ F Jan. 2, 1938 New York Usual Residence of Deced show 10c. City, Town or Location 10d. Inside City Limits notified at Director Frederick Adamstown Maryland 28a-f 1 Yes 2 XNo 10e. Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a United States 21710 3180 Blue Bell Court 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner Armed Forces?
1 X Yes 2 No
If Yes, Give 16 Black, White, etc. 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced White Completed 1955-63 Year or Dates. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Secondary (0-12) the Field Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental I ည Nellie Congdon Carl Thibault 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trac 3180 Blue Bell Ct., Adamnstown, MD 21710 / Wife Cynthia Margot Thibault 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June  $\overset{ ext{Date}}{1}$ 6, Page 1 1 Burial 2 XCres on 3 
Removal from State Resthaven Crematory 4 ☐ Donatter 5 ☐ Other (Specify) 2012 Frederick, Maryland 21. Signature of Fund 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. Frederick, MD 21701 9501 Catoctin Mountain Hwy. 23a. Part 1. Enter the disease shock, or heart failure or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final 20 Min Physician/ disease or condition resulting in death) Cardiac Arrest Medical Due to (or as a consequence of): Examiner <sub>b.</sub> Sepsis 8 hrs. Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to for as a supercurenes of. 8 Hrs. Intestinal Leak and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 24 Hrs. Hernia Surgery IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 2 No the detached 9 Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Severe Peripheral Vascular Disease 1 Tes 2 No 3 Probably 4 Unknown Completed Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 certificate has autopsy death? 1 Yes 2 No 2**X** No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 A Yes 2 No Other: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pl within 24 hours after death.

To the Funeral Director; After the completely filled in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 20a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Noise Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) June 16, 2012 D 31422 of person who completed cause or death (Item 20 23a) (Type, Print) 7211 Bank Ct., #200, Frederick, MD 21703 McKenna, M.D. Stephen 31. Date filed ( onth, Day, Year, 32. Registrar's Signature 28 2012 State Registrar

180 7 2 with the Maryland should be filed within 72 hours after death 21215-0036 BETTY Baltimore, Maryland P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012  $a^{M}$ 8:12 Betty Pritt Tripp June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Hospital 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) **Director** 1 🗆 M 2 🗡 F 232-32-6429 85 Yrs. 12/5/1926 West Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified MD Washington Hagerstown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Examiner must be Funeral 21742 1400 Haven Road, Apt. E22 U.S.A. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes. Give Completed 3 Widowed 4 Divorced White Year or Dates and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Food Service Supervisor Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pritt Ivy Pritt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Charles Barkley / Son 19222 GOlden Meadow Dr., Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Page 1 permit. Page 1.
Department of I Important: If it any injury or of once. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hagerstown, Maryland Haven Cemetery 6/15/2012 22. Name and Address of Facility 21. Signature Funeral Service Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ respiraton disease or condition resulting in death) Medical Due to (or as consequence of) Examiner ulmonari Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine pleuro Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to or as a consequence of) attending physician Physician/Medical sepsis 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant a 5 Other (specify) Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy disheres certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 Na Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Matural 5 Pending Accident Investigation in by the after deat Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours aft

To the Funeral Di

completely filled ir 24 hours a Funeral I Medical 29a. Certifier 📜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best-of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature

Registrar DHMH 17 Rev 06-2011 ttant

Attan Kasid, MD

28

31. Date filed (Month, Day,

and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

604

Frederick At.

South

32. Registrar' Signat

D0055054

Suite 409, Gaithersbon, mm In-120877

2 m

Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760

the !

Baltimore, Maryland 21215-0036

Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Andrew Kundrat, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

32. Registrar's Signature

D36716

29d. Date signed (Month, Day, Year)

June 15, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylar		artment c tificate c		and N	/lental Hy		4	012	2 207	
			Decedent's Name (First, Middle)	e, Last)	100 1		incate c	Death		2. Date of De	Reg. N	10.		3. Time of Deat	h
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	Funeral		Magnolia Cente  5. Social Security Number		. Age (In yrs. I	ast birthdav)	Lanha If Under 1 Y		r 24 Hrs.	8. Date of Bir		Princ		orge's	-7
	Director		006-42-4622	1 <b>∑</b> ∏ M 2 □ F	70	Yrs.		ays Hours	Min.	May 22	194	2	Cana	tay) 13	яgn
	how at	٦	Usual Residence of Decedent  10a. State 10b. County	,	10c Cit	y, Town or Lo	cation	·							_
	farylar Ba-f si tified	Director	Maryland Princ	e George's		Carro								0d. Inside City Lim	
	a or 28	٥	10e. Street and Number				10f. Zip Coo				10g. (	Citizen of N	What Coun		
	filed within 72 hours after death with the Maryland al Hygiene and the strength of the than "natural", or items 23a or 28a-f sho dent, the Medical Examiner must be notified at went, the Medical Examiner	Funeral	6406 Jodie Str				2078	34			Ca	nada			
<b>'</b> O	or iter		11. Marital Status 1 【X Never Married 2 ☐ Mar	12. Was Deced	es?		Vas Decedent of FYes, specify C	of Hispanic Or Cuban, Mexica	rigin? (Spe ın, Puerto	cify Yes or No- Rican, etc.)			e - Americ		
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פ	filed wall Hyg	Be	17. Father's Name (First, Middle, I	Last)		T COLPC		18. Moth	ner's Name	e (First, Middle,					_
ylai	should be file and Mental P 7 is marked o raumatic eve	은	Conrad Thibodea							gelier					
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relations Ovila Paquet -f			19b. Mailin	g Address (Str	eet and Numb	er or Rura	Route Numbe	r, City o	or Town, S	itate, Zip C	Code)	77/
<u>ရ</u>	Healt Healt Hem 2		20a. Method of Disposition	TTEIR	20b F		sition (Name of			)#203 G			City or To	ryland207	
m 0	Page 1 ment of ant: If it ury or o		1 ☐ Burial 2 【X Cremation 4 ☐ Donation 5 ☐ Other (S		tato C	emetery, cren	atory or other t tan Cre	place)					-	wn, state Virginia	3
Saltı	permit. Page 1 Department of Important: If i any injury or conce.		21. Signature of Funeral Service L		42			- 1		t Funer					
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			23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on each	line.				cardiac o	r respiratory an	rest,			Approximate Interval Between	
· .	Physician/ Medical		disease or condition resulting in death)	a. Due to (or	as a consequ		N091S	•						Onset and Death	_
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	ecute and I-trans	Exan	Cause (Disease or iinjury that initiated events resulting in death) Last	c. — Due to (or	as a consequ	ence of:									
200	cate be executed physician and the burial-transit	dical	.5,			3.,,									
9/20	trincate ng phy as the		IF FEMALE:	1											
٥ × .	ith cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	th 2 🗌 Feta	Ideath 3 🗌	Ectopic pregn	nancy			1		e of delive	•	
. <b>B</b> 0X	re dea / the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregna 9 ☐ Unknow	nt at time of d vn	eath 5∟	Other (specify	)				Moi	nth I	Day Year	
Σ	that the ned by e deta	by Pi	Part II. Other significant condition		th but not resu	ulting in the ur	nderlying cause	given in Part	I.	23e. Did to	bacco	use contr	ibute to the	e cause of death?	
as,	quires en sig ould b	ted	myelodys	plaster.	synd	nome				1 🗆 🕆	res 2	? □ No	3 🗌 Prob	ably 💢 Unkno	wn
o l	law re has be e 2 sh	Completed	, , , , , , , , , , , , , , , , , , ,		•					24a. Was a	sy	Р	rior to con	sy findings availab	
Vital Records,	n: Ine ficate r, pag		25. Was case referred to medical							1 Tes	rmed?		eath?	(Zho	
<u> </u>	ysicia s certi directo	To Be	examiner?	Hospital:	patient 2 🗌	ER/Outpatient	10	Place of Dear		only one) ne 5 🗆 Resid	- 0				
5 6	ng Pn fter thi		27. Manner of Death  1 Aurual 5 Pendin	28a. Date of		28b. Time of injury	28c. In	njury at		8d. Describe h					
VISION OF	death, tor; A the fu	Certificate:	2 Accident Investig	gation not be			M 1	Yes 2	No						
	after Direc		4 Homicide determine		etc. (Specify)		et, factory, offic	ce	2	28f. Location (S City or Tow			r o <b>r</b> Rurai F	Route Number,	
	lospita I hours unera	Medical	29a. Certifier 1 Certifying	Physician: To the bes	of my knowle	edge, death o	ccured at the ti	me, date and p	place, and	due to the cau	ıse(s) a	nd manne	r as stated		_
1	To the hospital or Attending Priysican: The law requires that the death certificate be executed within 24 hours after death, at after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3 🗆 Certifying	xaminer: On the basis of Nurse Reactioner: To	examination the best of my	knowledge, de	eath occurred at	t the time, date	and place	ne time, date are, and due to the	nd place cause	e, and due s) and ma	to the caus	se(s) and manner st ted.	ated
+	8 9 1 1		29b. Signature and title of certifier				29c. Lice	nse number		1	29d. Da	ite signed	(Month, Da	ay, Year)	
	10 W	-	30. Name and address of person v	vho completed cause of	of death (Item	23a) (Type. Pr	II)	10686	33		0	21	11/	<u>-</u>	
	' '		Dr. Sonia W	yone, &	200	Good	luck	Road	. Lo	luhan	Λ.	MD	207	06	
		_	04 D-4- El-J (144) h V 1	1											_

Registrar

DHMH 17 Rev 7/2009

JUN 2 3 2012 August 9. Aparts

Amen	nd item	#	18-Cecil Co-He Please	alth Dep Type or Prin	t-6-21 It in Blace	1 – 1 2 ck In	2-vd <b>delible</b>	lnk	. Ensı	ure A	II Copie	s Are	e Legible.	
			For	State of Ma		Оера	rtment c	of H	ealth a					
		_	State Registrar  1. Decedent's Name (First, Middle, Las)			Cert	ificate c	of D	eath_		2. Date of De	Reg. No		3. Time of Death
	Physicia		Helene M. Uccelle	•	e						Month 06 12	Da	2012	11:28 P <sup>M</sup>
	Medic Examin		4a. Facility Name (if not institution, give				4b. City, Tow					40	. County of Deat	h
			305 Miller Court  5. Social Security Number 6. Se	х 7 Аде	(In yrs. last birt	hdav)	Havre If Under 1 Y				8. Date of Bit	dh.	Harfor 9 Birt	hplace (State or Foreign
	Funeral Director			M 2 XF		Yrs.	Months Da	ays	Hours	Min.	(Month, Da	7 195	O Co.	PA
	nd how at	r	Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	n or Loc	ation						-	10d, Inside City Limits
	//arylar :8a-f s tified	recto	MD Harfor	d	Havı	re D	e Grac	e						1 ☒ Yes 2 ☐ No
	h the l 3a or 2 5e no	al Di	10e. Street and Number				10f. Zip Co					10g. Ci	itizen of What Co	untry?
	MD Harford Havre De Grace    MD   Harford   Havre De Grace   10s. Zip Code   21078   2								.	USA 14. Race - Ame	rican Indian,			
9	Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 No  1 Yes 2 N							, Puerto I	Rican, etc.)		Black, White			
Ş	To be the proof of										White Industry			
215	in 72 h e. kan "na Medio	dmo	(Specify only highest gra			(Give ki	ind of work do NOT use ret	one di		of worki	ng			
	d withi lygiene ther th	Be Co	12			Offi	ce Man			ula Mana	(First, Middle			Dentistry
Maryland	be file ental F ked of ic evel	To B	17. Father's Name (First, Middle, Last)  Joseph Uccelletti						RO:	se	• Butc		Surnamej	
ary	should and Ma is mar		19a. Informant's Name/Relationship (Ty	pe, Print)	198	o. Mailing	g Address (St.	reet a	nd Numbe	r or Rura	l Route Numb	er, City o	r Town, State, Zip	Code)
	and 2 s Health Sm 27 Sher tra		James Mazzone - h	usband			iller		ırt,		e De G		MD 210	
nore	age 1 ant of h		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif.		cemete	ry, crem	atory`or other	r place					lade1phi	
Baltimore,	permit. Pa Departme Importan any injur.		21. Sonatur of Funeral Service Licens		Holy S								neral Ho	
8	6 8 E 6 6	1	Kich and L.	Goods	٥,					_			, MD 219	
			23a. Part I. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on each line.	the death. Do	not ente	r the mode of			4	Cou			Approximate Interval Between Onset and Death
	Pnysician/ Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	pf):		(	Jie	ası	رها	nce	27	4 years
	Examiner	<u>_</u>	Sequentially list conditions,	b				_						
(7)	ecuted and -transit	xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence	Oτ):								
( ~	execul an and rial-tra	"	that initiated events resulting in death) Last	Due to (or as a	consequence	of):			-					
09	ath certificate be exe attending physician for use as the burial	dica	•	d										
68760	sertifica Iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If <u>ye</u> s, outcome o									23d. Date of de	livery
Box	death c e atter ed for u	Physician/Medical	in the past 12 months?	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown		h 3 L 5 C	Ctopic pred Other (speci	gnancy ify)	У				Month	Day Year
P.O. I	at the o		g Unknown  Part II. Other significant conditions or		ut not resulting	in the ur	nderlying caus	se giv	en in Part I	l,	23e. Did	tobacco	use contribute to	the cause of death?
	requires that the de been signed by the should be detached	d by									1 🗆	Yes 2	2- <b>₽</b> No 3□P	robably 4 🗆 Unknown
ord	w requ	plete									24a. Was	s an opsy	24b. Were au	topsy findings available completion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by										formed?	death?	3 2 □ No
ital	sician: certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital:				26. Pla Othe	er:			م مرماها،	6 Other (Spec	
of V	g Physical this	te: To	27. Manner of Death	28a. Date of injur	ent 2 ER/O y 28b.	utpatien Time of injury	28c.	Injury work	at		28d. Describe		6 ☐ Other (Spec ry occurred	(sity)
ion	tendin leath. .or. Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	1			М	1 🗆	Yes 2 🗆	-		(0)		15 1 11 1
ivis	lor At after o Direct d in by		4 Homicide determined	28e. Place of Inju building, etc	ry - At home, to . (Specify)	arm, stre	et, factory, of	ffice			28f. Location City or To			ral Route Number,
	ospita hours uneral	Medical	29a. Certifier 1 Certifying Phy	sician: To the best of	my knowledge,	death o	ccured at the	time,	date and	place, an	d due to the o	ause(s) a	and manner as sta	ated. cause(s) and manner stated.
	the Hin 24 thin 24 the Fu	Mec	(Check 2 ☐ Medical Examonly one) 3 ☐ Certifying Nurse  29b. Signature and title of certifier	se Practioner: To the b	best of my know	vledge, d	leath occurred	at the	e time, date	and place	e, and due to t	he cause	(s) and manner as ate signed (Mont	stated.
	<b>5</b>		29b. Signature and the great terminal	1	_ N	11)	230. 4	52	181	41		6	114/	2012
	20		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, P	rint) Paka	D	rive	#4	09 B	el /	Air MD	21014
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	6	barker	s						
	Registr	dl	JUN 14	CUIA Motor	your fo	3 , 194	900							

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 11:45 P Betty Lou White Medical <u>June</u> 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Hill haven Nursing Center Adelphi Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Months Hours Min. (Month, Day, Year) Director 219 48 5475 Maryland March 13, 1930 Usual Residence of Decedent show ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Prince George's Adelphi Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3210 Powder Mill Road 20783 United States permit. Page 1 and 2 should be filed within 72 hours after death of Department of Health and Mental Hygiene.
Important: I fitem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. Completed by 1XX Never Married 2 Married 1 Yes 2XX No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Disabled 4th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma E. Cross Aubrey B. White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9106 Dangerfield Road, Clinton, MD 20735 Walter Fowler (Cousin) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State June 14, 2012 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD Episcopal Church Cemetery 21. Signatur 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road. Clinton. MD 20735 23a. Part 1 Enter the disease, or complications that caused sheet, or heart failure. List only one cause on each line. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) PNEUMONI SPIRATION das Medical Due to (or as a consequence of) Examiner EMENT Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Dust to for as a consequence of burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) P in the past 12 months?

1 Yes 2 No The law requires that the death Day 4 ☐ Pregnant at time of death 9 ☐ Unknown the detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be del 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? certificate 1 Yes 2 No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar

1 was

only one)

29b. Signature and title of certifier

5- M. NAYAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

DHMH 17 Rev 7/2009

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

D-17874

38" AVE BROWNIND, ND 20722

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ate of Mary	land / Departme	ent of Health ar	nd Mental Hygiene

2012 20706

		I-For State Registrar	,	C	ertifica	te of D	eath		, ,	Re	eg. No.		
Physician	n/	1. Decedent's Name (First, Midd	le,Last)							Date of Deat Month	Day Y	'ear	3. Time of Death
Medical Examin	er	Robert  4a. Facility Name (if not institution	Lee Williams	mbor)		Jah (	City, Town, c	r Location (		June 7, 20	)12	ty of Death	1047 hrs
		10800 Indian Head Hi		(IIIDOI)			ort Wash		or Beauti			George	's
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birtho	lay) If	Under 1 Ye	ar If Unde	er 24Hrs.	8. Date of Birt	th (MM/DD/YY	YY) 9. Birtl	hplace (State or
Director		434 60 8264	1 M 2 F	70	)	Yrs. Months Days Hours Min. Jan 4					1942	Foreign Cou	n <sup>Intry)</sup> Texas
5.	ŀ	Usual Residence of Decedent								JC21,	17,12		
w any		10a. State 10b. County		10c. C	ity, Town o								10d. Inside City Limits  1 Yes 2 No
rland -f sho	힑	Maryland   Prince	e George 's		For	t Wash				- 14	2- 02	10-10-1	
ith the Maryland  23a or 28a-f show notified at once.	Director		- 1 II! -1			10	f. Zip Code ລາ	0744		10	Og. Citizen of	wnarcoun d Stat	
± 25 € 1		10800 Indian He		edent Ever in	us I	13 Was De			gin? (Spec	ify Yes or No-			can Indian, Black,
eath v	Funeral	1 Never Married 2 M	A 1 =				specify Cuba					nite, etc.	
after d	Š.	3 Widowed 4 Div	orced If Yes, Give Yea	' Viet		1 Yes	2 2 N	o specify:			Specify	<sup>/:</sup> Black	
nours		15. Decedent's Education (Spe	cify only highest grad	le completed)	) 16a. De		sual Occupa				16b. Kind of	Business/Ir	ndustry
36 thin 72 tee. than ",	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+) 2		Air Fo				,	   Mili	tarv	
5-00; led withi tygiene, other ti	팅	12 17. Father's Name (First, Middle,	Last)			ALL TO	ice	18 Mother	's Name (F	irst Middle M	Maiden Surnar		
	Bec		Lee William	s, Sr.					Janie	, , , , , , , , , , , , , , , , , , , ,		,	
		19a. Informant's Name/Relations		-	0.00	_	•	et and Num	nber or Rur		ber, City or To	own, State,	Zip Code)
MD d 2 shoulth and alth and an 27 is	1	Steven R. Willi	iams (Son)							ng, AFB			nton DC
imore, MD Z Pages 1 and 2 shou ment of Health and N or other traumatic		20a. Method of Disposition  1 X Burial 2 Cremation	n 3 Removal fr			Disposition y or other p	(Name of collace)	emetery,		ate	20c. Location	n - City or 1	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite Important: If ite Impury or other to		4 Donation 5 Other Sp	pecify:		rlingt	on Nat	ional C	emeter	7		Arlingt	on, Vi	rginia
Baltimo permit. Pages Department o Important: 1		21. Signature of Fuperal Service				22. Name	and Addres	ss of Facility	Lee Fu	meral H	ome,Inc	6633 C	ld Alexandria
Physician	+	Ž3a. Part I. Enter the disease, or		0 ( 5 3 aused the dea	ath. Do not		ry Road ode of dying				est, shock, or h	neart	Approximate Interval
Medical	4	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Sharp Force Injuries of Neck  Due to (or as a consequence of):									Between Onset and Death		
Examiner	-												
	_	Sequentially list conditions,	b										
	흵	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence	e or):								
gi, q	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	e of):		-						
760, icate be executed physician and the burial - transit		UNPENDED	d	<u> </u>									
60, ate be e ohysicia	Medical	IF FEMALE:		utaama af ar							23d. Date	of dolivon	
6876 rtificat ing ph		3b. Was decedent pregnant in the past 12 months?		outcome of pr irth	egriancy 2	Fetal d	eath 3	Ectopic	c pregnancy	/	Month	Da	ay Year
Box 687 ne death certific the attending 1 hed for use as the	흥			ant at time of	death 5	Other	(Specify)				î		
4 ×4 E	Physician	Part II. Other significant condit	9		ot resulting i	n the unde	lying cause	given in Pa	art I,	23e. Did tol	bacco use cor	ntribute to the	ne cause of death?
ords, P.O. w requires that the second	2	Market State Control					, ,			1 Yes	2 🗸 No	3 Probe	ebly 4 Unknown
Records,  The law require ficate has been si page 2 should b	Completed									24a, Was a			opsy findings available
e law e has ge 2 sl	힐								_	autops perform 1 Yes 2	med?	death?	ompletion of cause of
Vital Rechysician: The I	3	25. Was case referred to medica					26.Plac	e of Death (	(Check only		- NO	1 🗸 163	2 NO
Vita	ğ 	examiner? 1 ✓ Yes 2 No	Hospital: 1 1	npatient 2	ER/Outp	patient 3	DOA	Other <sub>4</sub>	Nursing H	lome 5 .	Residence 6	<b>✓</b> Other:	Scene
ling Ph		27. Manner of Death	28a. Date (Month Jun 7, 2	of Injury Day, Year)		ne of Injury		ury at Work	10.		ow injury occu		ıf
sion ttend death. ctor: y the f		⊟ Pend	stigation		0000 F			Yes 2	No				
Division of Vital ral or Attending Physician: rs after death. al Director: After this certi led in by the funeral director.	Certification:	deter	d not be	of Injury - Al			ctory, office	building, etc		or Town, St	ate)		al Route Number, City
y file		4 Homicide 29a. Certifier	hysician: To the bes	Single Fa			at the time.	tate and pla					ashington, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical		miner:On the basis of and manner s	of examination									
F.2 F.8	\$	295. Signature and title of certifie		lated.	1		29c. Licen	se number			29d. Date sig	ned (Mon	th, Day, Year)
00		(0.111	111	191	The same		0.0	.M.E.			June 8, 2	012	
was	ŀ	30. Name and address of person					1		72	l			
3-E	┙		Assistant Medic			W. Balti	more Stre	et, Baltir	more, M	D 21223			
Stat Registra		31. Date filed (Month, Day, Year)	012	gistrar's Sign	La La	and of							
DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL							OCME						

2013 Charles

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	ryland / Depa			Mental Hy	giene		
			Registrar  1. Decedent's Name (First, Middle, La	et)	Cer	tificate of D	eath	2. Date of De	Reg. No. 20	12 20	70
г	Physicia			Wundram				Month June	Day `	3. Time of Do 912 5:01	
	Medic Examin		Gary Lewis  4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Dea		4c. County of		Г
محديده			21006 Park Hall	Road		Вс	onsbor		Washington		
12.2	Funeral		5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th y, Year)	Birthplace (State or F Country)	oreign
il.	Director		217-62-6197 Usual Residence of Decedent	XM 2□F	59 Yrs.					Maryland	
	and show lat	ō	10a. State 10b. County		10c. City, Town or Lo	cation		, , , , , , , , , , , , , , , , , , ,	,,,,,,,	10d. Inside City	Limits
	Maryl 28a-f atified	rect	Maryland Washi	ngton	Boonsbor	0				1 🗆 Yes 2	X No
	a or s		10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	at Country?	
	th wit	Funeral Director	21006 Park Hall				21713	2 77 11		U.S.A.	
"	or iter	by Fu	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🗓 N		Was Decedent of His f Yes, specify Cubar	spanic Origin? (S , Mexican, Pue	rto Rican, etc.)		- American Indian, White, etc.	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		3 Widowed 4 X Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White	
2-0	2 hour "natu dical	Completed	15. Decedent's I (Specify only highest g	ducation rade completed)		dent's Usual Occupa kind of work done di		orkina	16b. Kind of Busi	iness/Industry	
121	thin 7	om	Elementary/Secondary (0-12)	College (1-4 or 5+	life D	O NOT use retired)					
	led within Hygiene. other thai	Be C	12 17. Father's Name (First, Middle, Last)			Truck Dr		ame (First, Middle,		<u>ransportati</u>	Lon
an	be file ental rked c	인	Lewis Wundram					Jane You	,		
Maryland	should be filed and Mental Hy is marked oth anmatic event		19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street a				te, Zip Code)	
	nd 2 sl salth a n 27 i er tra		Leah A. Dustin		1406	O Brighto	n Dam R	oad, Cla	rksville,	Maryland 2	1029
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 🏾	Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place	e)	Date	20c. Location - C	City or Town, State	
Ë	nit. Page 1 sartment of cortant: If it injury or o		4 Donation 5 Other (Spec	ify)	Stauffe	r Cremato	ry 06	/18/2012	Frederic	k, Marylan	d
Bai	permit. Page Department of Important: If any injury or once.		21. Ignature of Funeral Service Licer	J. Cha	non	2. Name and Address 06 01d Na				eral Home, <u>Ma</u> ryland 21	
			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	pplications that caused tone cause on each line.	he death. Do not ente	er the mode of dying	, such as cardia	ac or respiratory ar	rest,	Approximate Interval Betwe	een
	Phy ician/	\$ 1	Immediate Cause (Final disease or condition	Ciri	hosis					ON IE	サ
2000	Medical Examiner		resulting in death)	Due to (or as a	consequence of):						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						
	ted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury	540 10 (01 40 4							
	ate be executed physician and the burial-transit	Ex	that initiated events resulting in death) Last	Due to (or as a	consequence of):						
00	ate be ex physician the buria	edical		d							
68760	rtifical ing pl e as tl	Me	IF FEMALE:								
Вох 6	ne death certific. r the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?		Fetal death 3		/		23d. Date Mont	of delivery h Day Yea	ar
Ä.	the a	ıysic	1 Yes 2 No 9 Unknown	4 Pregnant at t 9 Unknown	time of death 5 L	Other (specify)	_				
P.O.	requires that the been signed by ' should be detacl	by Pr	Part II. Other significant conditions	contributing to death but	t not resulting in the u	ınderlying cause give	en in Part I.	23e. Did t	obacco use contrib	oute to the cause of dea	#h?
S,	uires n sigr uld be	ed b						.   1 🗆	Yes 2□No 3	□ Probably 4 Un	ıknown
of Vital Records,	iw required by the second seco	Completed						24a. Was		ere autopsy findings ava	ailable use of
Rec	The law ate has page 2:	Som							rmet/ de	ath? □ Yes 2 □ No	
ta	ysician: The s certificate director, pag	Be (	25. Was case referred to medical examiner?	Hospitali			ce of Death (Ch	eck only one)	7-(		
fVi	Physia this c	မှ	1 Yes 2 No		nt 2 ER/Outpatier		4 ☐ Nursing		dence 6 Other		
0 U	ding I h. After funer	ate	1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		work?	at Yes 2 □ No	28d. Describe r	now injury occurred		
Sio	il or Attendir after death. Director: Af d in by the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	28e. Place of Injury	y - At home, farm, str		100 2 2 110			or Rural Route Number,	9
Division	tal or irs afte al Dire		4 - Homicide determined	building, etc.	(Specify)			City or Tov	vn, State)		3
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check Medical Exan	vsician: To the best of mainer: On the basis of example of the pasis of example of the pasis of the vision of the pasis of	amination and/or inves	tigation, in my opinion	n, death occurre	d at the time, date a	and place, and due to	o the cause(s) and mann	er stated.
	To # To #		29b. Signatore and title of certifier			29c. License		,	29d. Date signed (	Month, Day, Year)	
	•		30. Name and address of person pho	completed cause of dea	ath (Item 23a) (Type. F	Print)	17.003	<u> </u>	0/10/	10	
W	-5		PRAYEZY BE			DE (VE, Th	upil	(CK, M	9 2170	12	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	ball					

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FRANCES RACHAEL WASTLER 9:25A JUNE Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours Min 218-38-1788 Director 1 🗆 M 2 🗶 F 12/29/1941 MD 70 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Frederick 1 Yes 2 No MD Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n 0 Funeral 21788 USA 10834 Putman Rd. · death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11 Marital Status Examiner Armed Forces?

1 Yes 2 No ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify Specify: White If Yes, Give Year or Dates "natural", Completed 3 🛮 Widowed 4 🗆 Divorced the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry of Health and Mental Hygiene. Fitem 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Silas Pierce Rice Lillie Mae Hahn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 9 Adams Ave., Emmitsburg, MD 21727 Anna McManus/daugther 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Blue Ridge 06/15/2012 Thurmont, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine executed Cause (Disease or injury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day Month 5 Other (specify) Pregnant at time of death the a signed by to be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 Jas autopsy performed? certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After to completely filled in by the funer 1 🔽 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractitioner: To the best of my knowledge, death occurred at the fame, date and place, and to the time place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who

31. Date filed (Month, Day, Year)

32. R wi trar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Frederick MD, 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 200 12:38 PM LESLIE ANN YOUNG Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death tospital Easton albot 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Min. 095-50-8234 **Director** 56 05/02/1956 NEW YORK il Hygiene. I other then "neturel", or items 23e or 28a-f show vent, the Medical Examinar must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits TALBOT NEAVITT 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 6163 LONG POINT RD. 21652 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Š 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) FLIGHT ATTENDANT COMMERCIAL AIRLINES Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Health and Mental Paga 1 end 2 should be ANN R. ROSWALL CLAYTON OSCAR GRANT 19a. Informant's Name/Relationship (Type, Print) t: If Item 27 is n 7 or other treum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6163 LONG POINT RD. NEAVITT, MD 21652 STEVEN T. YOUNG/SPOUSE timore, 20a. Method of Disposition 20b. Place of Disposition (Name of CH记为中比内域的/CREMATED ON Date 20c. Location - City or Town, State ₽ 1 🗍 Burial 2 💢 Cremation 3 🗋 Removal from State Department of Importent: If any Injury or 06/08/2012 STEVENSVILLE, MD 4 Donation 5 Other (Specify) CENTER 21. Signatury of Fundal of the Licentee FENEROWSAGOTHELEGENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST. EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final GASTROINTESTINAL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HEMORKAGIC SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). To the Hospitel or Attending Physicien: The law requires that the deeth certificeta be executed within £2 hours after death.

To the Funerel Director: After this certificete hes bean signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit or Attending Physicien: The law requires that the deeth certificeta be executed ALCOHOLIC LIVER that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 N 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ၉ 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes ☐ Accident Investigation 2 🗌 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier D0059487 725 30. Name and orders of person who completed cause of death (Item 23a) (Type, Print) JOHN BOTSIS MD 21601 10 31. Date filed (Month, Day, Year) State 32 Registrar's Signature

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ tor 11:31PM lune 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NIA 1-1 6 Sex Age (In yrs. last birthday If Under 1 Year If Under 24 His **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Y 1 M 2 F Hours Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City, Limits Examiner must be notified at by Funeral Director Homore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a TON or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) ပ other traumatic Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is n 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21201 MCCo laylor Baltimore 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Baltimore 30/2012 4 ☐ Donation 5 ☐ Other (Specify) Signature Countries Service License 22. Name and Address of Facility -Linera O 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph∫sician/ disease or condition resulting in death) 10 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Tany leading to impaction cause. Enter Underlying Cause (Disease or iinjury and -transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical P.O. Box 68760 the attending phone IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 1 ☐ Yes ∠ ∟ 9 ☐ Unknown detached Unknown signed by to Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 № No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performe certificate Yes 2 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending nours after death.

neral Director; Af
filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D To the Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed who completed cause of death (Item 23a) (Type, Print) 501 Dolbnin State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June 2012 William Lee Allen 9:25 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House 6. Sex If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In vrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Days Hours Min (Month, Day, Year) Director 154-24-4739 1X M 2 D F Feb 11, 1936 Pennsylvania 76 Usual Residence of Deceder or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Ves 2 X No MD Montgomery Olney 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2917 Clovercrest Way 20832 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 If Yes, Give Year or Dates. 1956–58 1 ☐ Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired!

Manufacturers
Representative (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmitted. Elementary/Secondary (0-12) College (1-4 or 5+) Women's Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Allen Rose Hassan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Allen / Wife 2917 Clovercrest Way Olney, MD 20832 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 KI Cremation 3 Removal from State Final Journey Crematory 6/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M MD 21029 28a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Obstructive Pulmonary Disease Chronic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): certificate be executed burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physicien Physician/Medical Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ō in the past 12 months? Day ned by the at detached for Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ٰا pe cate has been sig page 2 should b Completed 1 🔀 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 24 hours after death.

Funeral Director: After this certificate I etely filled in by the funeral director, pag 1 Yes 2 🗌 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSpice 1 Yes 2 🛛 No မှု 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one the

OX

State Registrar

Debrah Miller 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) **JUN 29** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and title of certifier

29c. License number

R143201

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 18 Day 2012 Year Physician/ June OM M Ina M. Banoczi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crownsville Anne Arundel Fairfield Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/11/1932 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Country) 299-26-0327 Director 1 🗆 M 2 😾 F 80 Ohio show or 28a-f shov be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1X Yes 2 □ No Crownsville Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a amy injury or other traumatic event, the Medical Examiner must by once. Funeral U.S.A. 21032 1454 Fairfield Loop Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🏋 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify. Specify: 3 ☒ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Sylvia Mae McCollum John Roy Turner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1751 Urby Drive Crofton, Maryland 21114 James Banoczi Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 06/26/2012 Youngstown, Ohio 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, 21. Signature of Funeral Service Licensee 6009 Harford Road Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed<sup>4</sup> this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: ြို 1 🗌 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work?
1 Yes 2 No 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 12:20P 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death beth timor UNSING If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2¥F Feb. 24, 1918 Months Days Min. 216-18-4028 94 Yrs Maryland Director Usual Residence of Decedent shov 10b. County filed within 72 hours after death with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 □ No Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 21227 United States 3320 Benson Ave. Was Deceue... Armed Forces? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify. "natural", 3XXWidowed 4 □ Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired)  $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 8\,\text{th} \end{array}$ College (1-4 or 5+) N/A Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o ဂ္ Samuel Brown Sadie Galperina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4602 Rehbaum Ave., Arbutus, Maryland 21227 Helen Horine / Daughter Baltimore, 1 other 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place)

Loudon Park Cemetery 1 Nurial 2 Cremation 3 Removal from State ŏ permit. Page Department of Important: If any injury or once. Baltimore, Maryland 4 Donation 5 Other (Specify) Funeral Service Licensee 22. Name and Address of AMIBROSE FUNERAL HOME OF LANSDOWNE 2719 Hammonds Ferry Rd., Lansdowne, Maryland 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ liertension disease or condition Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events anding physician and use as the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy been signed by the atter should be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ☐ Pregnant at time of death☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 X No 1 🗌 Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 D No Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6  $\square$  Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ltimur e 20 WW onson State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 5:45 rown June 201 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** altimou NA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, **Funeral** 900 Days Months Hours Country) 1 M 2 N N Aug **Director** Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director attimal 1 Nes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #313 Funeral 21213 2200 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11. Marital Status Armed Forces' Black, White, etc 1 Never Married 2 Married Yes 2 No Yes, Give þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Blac "natural", Completed 3 Widowed 4 Novorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry ont of Health and Mental Hygiene.

t: If item 27 is marked other than to other traumatic event Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Willie Mae 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21213 Informant's Name/Relationship (Type, Print) #313 rout altimore, Marjorie 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) Surial 2 Cremation 3 Removal from State Important: I any injury o 4 Donation 5 Other (Specify) rleigh (emetery Juneral Service 21. Signat teights Balto 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caudiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DSI Same dh disease or condition Medical resulting in death) Due to or as a consequence of): **Examiner** ration Sequentially list conditions, if any, leading to immediate cauch. Enter Underlying Cause (Disease or linjury Examine Due to (or is a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day for Pregnant at time of death been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? cate has by page 2 s 1 Yes 2 No this certificate Yes 2 No Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify, ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After injury 1 Natural 5 Pending 1 Yes 2 No thin 24 hours after death.

the Funeral Director: As pmpleted filled in by the fu Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29d. Date signed (Month, Day, Year) Signature and title of certifier H0063097 erson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Morgan

Date filed (Month, Day, Year)

29

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32. Regis ra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HUBERT EARL BAGLEY 5:26  $\mathbf{P}^{\mathsf{M}}$ JUN 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **BETHESDA** MONTGOMERY WALTER REED NATIONAL MEDICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 27 1 Birthplace (State or Foreign Country) **Funeral** Social Security Number 7. Age (In yrs. last birthday 1**X** M 2 □ F Days Min Hours 228-36-6565 Director 78 1933 NORTH CAROLINA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 X Yes 2 No MD PRINCE GEORGE'S CLINTON 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11301 DEMMY WAY 20735 USA items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 1

If Yes, Give Black, White, etc. "natural", or 2 1 Never Married 2 X Married 2 No ARMY 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12TH COMBAT MEDIC COVERNMENT other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM BAGLEY NONER WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Page 1 and 2 11301 DEMMY WAY CLINTON, MARYLAND 20735 ANNIE MAE BAGLEY/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o o 1 

Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD VETERANS CEMETERY 7/5/2012 CHELTENHAM, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician! SUBARACHNOID BLEEDING WITH HERNIATION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions If any, leading to immediate cause. Enter Underlying Due to (or as a consequence cry Exami Cause (Disease or iinjury that initiated events resulting in death) Last -tran Due to (or as a consequence of): Physician/Medical that the death certificate be P.O. Box 68760 nding physise as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death the by signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CORONARY ARTERY DISEASE Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed' 2 🗌 No 1 Yes Yes 2 V No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\subseteq\) Nursing Home \(5 \subseteq\) Residence \(6 \subseteq\) Other (Specify) 1 🔲 Yes 2 **X**No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be the Funeral Director: / npleted filled in by the 1 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after within 24 hours a

To the Funeral E

completed filled Medical 29a. Certifier 1 XX Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of MA 244981 JUN 25 2012 of person who completed cause of death (Item 23a) (Type, Print) WALTER REED NATIONAL MEDICAL CENTER ASHEESH KUMAR, BETHESDA, MD 20889 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ June 25, Catherine Laura Bloom 4:55 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford 1010 Longstream Court Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** (Month, Day, Year, 187-18-7739 Director 1 M 2 XF Yrs 89 Oct. 15, 1922 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 1010 Longstream Ct. 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No 0 ģ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural" Completed 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 8 Homemaker other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) မ Laura (unk) Smiley permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. Joseph (unk) Cosgrove 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pat Powers / Daughter 1010 Longstream Ct., Bel Air, Maryland 21014 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Hill Svcs, LLC 6-29-2012 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service 1317 Cokesbury Road, Abingdon, Maryland 21009 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Interval Between Onset and Death e ate Cause (Final Physician/ Medical resulting in death) **Examiner** Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 Yo
9 Unknown Year Month Dav Pregnant at time of death signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No Yes 2 the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA . Manper of Death

1 X Natural

2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: the Hospital or Attending 5 Pending 1 Yes 2 No Investigation within 24 hours after deat To the Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29d. Date signed (Month, Day, Year)

State Registrar

55

of death (Item 23a) (Type,

June25,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ June 27, Day 2012 ea 2:52 AM Marie Cathleen Lambert Buckleman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Brightview Assisted Living Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month, Day, Year) uly 26,1920 Min 1 □ M 2 🏝 F Maryland 91 220-03-5950 Director July Usual Residence of Decedent 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 USA 8100 Rossville Blvd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces 1 Never Married 2 Married Completed by Yes 2 XNo Maryland 21215-0036 1 Yes 2 No Specify. white If Yes, Give 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Camera Mart Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisherships is marked o မ Samuel Lambert Anna M. Hartenstein other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 2418 Sandy Brook Lane-Midlotaian, Virginia 23112 William Philip Buckleman-son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery June 30,2012 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Day ned by the a 1 ☐ Yes 2 ☐ Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No Yes 2 No 1 Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? STSSISTED LIVING 2 No Other: 4 Nursing Home 5 Residence 6 Other 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 28 30. Name and address of person who completed cause of death (Item 23a), (Type, Prin tolvive Ellicott 9055 DANE State JUN 29 2012 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 2012 Year Physician/ June 24, Edward Charles Branges 3:28 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1830 Greenplace Terrace Montgomery Rockville 5. Social Security Numbe 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov . 5 , 9. Birthplace (State or Foreign **Funeral** Months Days Hours New York 105-24-6841 87 Nov. Director be filed within (2 1000).

Anntal Hygiene.

arked other than "natural", or items 23a or 28a-1 silon.

Aric event, the Medical Examiner must be notified at Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1X Yes 2 ☐ No Maryland Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1830 Greenplace Terrace 20850 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces?

1 
Yes 2 
No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Year or Dates. Korea Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer should be filed with and Mental Hygien Is marked other th Industrial Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မှ Robert Branges Julia Polka permit. Page 1 and 2 should be Department of Health and Men Important: If Item 27 Is marke any injury or other traumatic once. rraumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Branges/Daughter 308 Brennen Circle, Roseville, California 95678 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of June 26, 20c. Location - City or Town, State Montgomery 1 Burial 2 X Cremation 3 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crematorium, 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc M00198 300 West Montgomery Ave., Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 8 Months Physician/ Gastric Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy I or Attending Physician: The law requires that the death after death.

Director: After this certificate has been signed by the atter in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Dav Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 X No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital o within 24 hours af To the Funeral Di Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 2 | 3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month. Day, Year, D43083 June 25, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9707 Medical Center Drive #300, Rockville, Maryland George A. Sotos, M.D. 32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 012 Physician/ June 25. Helen C. Branson 10:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6. Sex 1 ☐ M 2 🛣 F 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 12. 27, 1917 718-14-0401 94 Yrs Michigan Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? ò Funeral 20877 "natural", or items 23a 419 Russell Avenue #117 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc þ 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: If Yes, Give Specify. 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 2 should be filed with and Mental Hygis 7 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Helen Louise O'Donnell Ernest W. Christen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh ment of Health a tant: If item 27 is 16840 Hardy Road, Mt. Airy, Maryland 21771 Helen L. Branson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 29, permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Suitland, Maryland Cedar Hill Cemetery 4 Donation 5 Other (Specify) 2012 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 M00198 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. enset and Death Immediate Cause (Final Longestin Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ding physician and se as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical I or Attending Physician: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicial IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2 completed filled in by the funeral director, page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗹 No 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier K. Robert Buscul 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar IV. ROBERI

31. Date filed (Month, Day, Year)

29 2012

Baltimore, Maryland 21215-0036

Box 68760

P.O.

BIRSCHBACH, MU)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Wanda Josephine Clancy z S 11:40 AM 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Agnes Hospital Baltrinore Social Security Number ge (In yrs. last birthday) 8. Date of Birth **Funeral** If Under 24 Hrs 9. Birthplace (State or Foreign Country) PA 178-14-2530 90 01/15/1922 **Director** 1 🗆 M 2 🕱 F Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Catonsville MD Baltimore 1 ☐ Yes 2 X No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21228 912 South Rolling Rd., Apt. 116 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give /940 — Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. , or þ 1 Never Married 2 Married Je filed within ...
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arked other than "natural", o
~vent, the Medical Exar Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Specify. Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Nursing 5+ other traumatic event, Be 7. Father's Name (First, Middle, Last)

Ignatius Koszalka 18. Mother's Name (First, Middle, Maiden Surname)
Waleria Siebielec and Mental is marked o ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s t of Health a If item 27 i Robert S. Clancy / Son 1 Dutton Ct., Catonsville, MD 21228 20a. Method of Disposition

12 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If any injury or once. injury or St. Josephs Cemetery 07/03/2012 Palm Bay, FL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Bailey Funeral Home and Cremation Service, PA 4023 Annapolis Rd., Halethorpe, MD 21227 m01452 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ hemormagic stroke with hydrocephal Acute disease or condition resulting in death) day Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ for in the past 12 months? Year Pregnant at time of death Yes 2 No 1 Yes 2 Unknown P.0. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown should 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy death? 2 No Yes To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Tes 2 No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: within 24 hours after death.

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| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only on 29b. Signatule and title of certifier 29d. Date signed (Month, Day, Year) MO D5857 2012 June 28 12 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Waryland Tao 900 Carton Baltimore unn Avenue 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Wanda

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Ratient Baltimore.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Important: 10 Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any Injury or other traumatic event, 10 Million Examiner must be notified at once.		4 Donation	Cremation 5 C Other (5		State		y, crema	atory or o	ther place		í	Coll >	1	Location Ltim	•	own, State	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3:30 A MORTH 20142 Da4 Physician/ Ila Dean Carnaggio Medical 4b. City, Town, or Location of Death Abingdon a. Facility Name (if not institution, give street and number) 4c. County of Death Harford **Examiner** 217 Lodge Cliff Ct. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 193-14-6166 1 🗆 M 2 🖵 F Director 88 PA 06/17/1924 ms 23a or 28a-f show must be notified at 10d Inside City Limits 0a. State 10c. City, Town or Location Director Abingdon 1 Yes 2 No MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 217 Lodge Cliff Ct. 21009 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Examiner Black White etc. item 27 is marked other than "natural", or other traumatic event, the Medical Examin þ 1 Never Married 2 🙀 Married 🗌 Yes 2 🙀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Je filed with the state of the (Give kind of work done during most of working life. DO NOT use retired) 1<sup>Elementary/Secondary (0-12)</sup> College (1-4 or 5+) Copper's Co. Machine Operator should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Custar Foor Gaynell Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sh iment of Health a tant: If item 27 is 217 Lodge Cliff Ct., Abingdon, MD 21009 John Carnaggio = Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 06/29/2012 4 Donation 5 Other (Specify) Gardens of Faith Baltimore, MD 21. Signatury of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home, 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Ently the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Metastatic Physician/ months disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Day 1 Yes 2 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy this certificate has 2 No 2 X No 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 2 Accident 3 Suicide 5 Pending injury M Investigation filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) DA5530 6-26-2012 lain MiD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) use or death (Item 23a) (Type, Print)
510, Upper Cheapeake Drive, Belair 21014

DHMH 17 Rev 06-2011

State Registrar

S. SIUA SAILAM

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 2012 13128 reguos Medical WA 4a. Facility Name (if not Institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 3altmore 6+ Marylenn If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 5. Social Security Number (Month, Day, Yea 09/22/1954 Min 218-62-0136 **Director** 1 🗆 M 2 🔀 F MD 57 Usual Residence of Decedent 23a or 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director Windsor Mill MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21244 USA 92 Western Wind Circle Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 Never Married 2 Married 3 Widowed 4 Divorced ☐ Yes 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: Black Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore City Housing Authority Security Guard Be Baltimore, Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Evelyn Cooper Benjamin Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92 Western Wind Circle Windsor Mill, MD 21244 Ericka Harris / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Woodlawn Cemetery June 30, 2012 Windsor Mill, MD e of Funeral Service 22. Name and Address of Facility
John L. Williams Funeral Directors, P.A. 4517 Park Hohts Ave Baltimore, MD 21215 Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ avelig 4 cm2 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a s the burial-To Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Wunknown 24a. Was an 24b. Were autopsy findings available is certificate has to director, page 2 s autopsy prior to completion of cause of death? 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after deau.

To the Funeral Director: After Matural Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 33485 ss of person who completed cause of death (Item 23a) (Type, Print) 01 1 timore

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year Physician/ 529 PM JUN James Dempsy 2012 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore City Hospital of If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director 1 🗶 M 2 🗆 F 65 Mar 18, 1947 Maryland or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 Yes 2X No Elicott City MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 USA 3101 Wheaton Way #J 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: white I Hygiene. other than "natural", 3 Widowed 4 Divorced Year or Dates as: 15. Decedent's Education 16a. Decedent's Usual Occupation unk unk 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ! ည James J. Dempsy Sr Helen Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 4460 Saddle Horn Trail Middleburg, FL 32068 George Childs/brother in law 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) in state cemetery, crematory or other place) Signature of nald Signature of nald Signature State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Due to (or as consequence of): disease or condition resulting in death) Medical Examiner Dysphagia as a consequence of: Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Cerebrovascular To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23h Was decedent pregnant in the past 12 months? Month Dav Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes mellitus 1 Yes 2 No 3 Probably 4 Onknown Atrial fibbrilation 24b. Were autopsy findings available prior to completion of cause of death?

1 
Yes 2 24a. Was an autopsy performed? Yes 2 No certificate has filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 은 28c. Injury at 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending s after death. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar Patrick

31. Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

M Ginkey

10054482

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day 24 Physician/ 2012 JUNE 4:08 A M VERNON RAY DOZIER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Director 240-54-2173 1 XM 2 □ F Yrs SEPT. 25 1938 NORTH CAROLINA Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director PRINCE GEORGE'S MD MITCHELLVILLE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2005 CONNORS COURT #G 20721 USA items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ō à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. BLACK If Yes Give "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE SHIPPING CLERK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ MADGIE HUNTER VERNON O. DOZIER . Page 1 and 2 should b iment of Health and Mer tant: If item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9804 LAKE POINTE COURT # 304 LARGO, MARYLAND MILIKA DOZIER/DGT. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition ō <u>=</u> 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 0 Important: If any injury or MD NATIONAL CEMETERY: 7/6/2012 LAUREL, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ATAL CARDIAC disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine Doe to for as a nonscourance of cause. Enter Underlying nding physician and use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy atten in the past 12 months?

1 Yes 2 No Month Vear Day Pregnant at time of death Other (specify) signed by the at Id be detached for ☐ Pregnan. ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsv performe death? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Certificate: To Be Other: 1 Tyes 1 🗌 Inpatient 2 💢 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death ner of D

Natural

A 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred After injury 5 Pending neral Director: A filled in by the fu Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Signature and title of 29c. License number

State

31 Date filed (Month, Day, Year

29 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA FAIR 3001 HOSATAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2<sup>Day</sup> Month 06 2012 Nancy Welch Dalton 8:05 РМ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Sunrise Of Annapolis Annapolis If Under 24 Hrs. g. Birthplace (State or Foreign 5 Social Security Number 7. Age (In yrs. last birthday) If Under Year 8 Date of Birth **Funeral** 1 🗆 M 💥 🗆 F Months Days Hours Min (M87/1079/1930 Rhode Island 035-22-9521 81 Yrs Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Yes 2 No Annapolis MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21401 800 Bestgate Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Deced.
Armed Forces?
Yes X No 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 🏻 ☐ No Specify: If Yes, Give Year or Dates Completed ¾☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working rould be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francis Welch Marion Hesse and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health item 27 i 3505 Westgate Dr., Ellicott City, MD 21042 Keith S. Dalton / Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial X☐ Cremation 3 ☐ Removal from State 6/29/2012 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each lipe. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate has performed? Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 100 မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

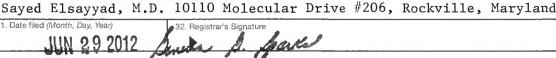
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2012 Physician/ Charles Elbert Dorsett 24. 12:35 PM June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Center Rockville Montgomery 8. Date of Birth (Month, Day, July 3, 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 1 X M 2 🗆 85 North Carolina 577-32-4415 1926 Director Usual Residence of Decedent f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director · 28a-f Maryland Montgomery Rockville 1 Yes 2 K No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 23a Funeral 20852 4706 Topping Road United States items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. ģ ō 1 Never Married 2 X Married and 2 should be filed within 72 hours after X Yes 2 No 3altimore, Maryland 21215-0036 White 1 Yes 2X No Specify: If Yes, Give Year or Dates. WW II "natural" 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Tester Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Melvin Dorsett Minnie Ethel Wilson and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20852 f Health airem 27 i 4706 Topping Road, Rockville, Maryland Nancy M. Dorsett/Wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot Page 1 Parkiawn Memorial<sup>e</sup> Park 1 X Burial 2 Cremation 3 Removal from State June 2012 Rockville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Juneral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc M00198 300 West Montgomery Ave., Rockville, Maryland 20850 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph si ian/ Failure To Thrive disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) Possible Lung Cancer Sequentially list conditions, Examine d any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown been Coronary Artery Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsv perform death? 2 🗆 No 2 X No 1 Tes ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica ted filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 X Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

(Check



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year) June 26, 2012

20850

29c. License number

D62435

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 9:05 06 Joyce Carolyn Dykman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Hospice Center If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) 10/15/1938 Days Hours Min. Director 1 □ M 2X□ F Pennsylvania 209-30-8184 73 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 - No Baltimore MD 10f. Zip Code ŏ 10e. Street and Number 10g. Citizen of What Country? Funeral or items 23a 1306 West 37th Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify. Specify. 3√ Widowed 4 Divorced Year or Dates White of Health and Mental Hygiene. Item 27 Is marked other than "natur other traumetic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Religious, Non-Profit Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Wilma Johnston Frank Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 West 37th Street, Baltimore, MD 21211 Kenneth B. Emmerling / Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ = 5 1 Burial 2 Cremation 3 Removal from State Important: If any injury or once, 4 Donation 5 Other (Specify) 6/29/2012 Beltsville, MD <u>Chesaneake Crematory</u> Signature of Funeral Service Licenses 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 Dorota Marshall s 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) 20 U 00 0 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed 24 hours after death. attending physician and for use es the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 $^<$ IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the sempletely filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) C ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 2 🗌 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

DHMH 17 Rev 06-2011

only one

Signature and

29b

completed cause of death (Item 23a) (Type,

29c. License number

D0071287

29d. Date signed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1834 Month 4c. County of Death Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 8. Date of Birth (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 M 2 MARY 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 2 No 1 Yes 2 If Yes, Give 1 Yes 2 No 3 🗌 Widowed 4 🗌 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 163 Ja / 7:6 729701702 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Secondary (0-12) College (1-4 or 5+) MARI ural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number of 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Nam Date remetery, crematory or other place) 1 Rurial 2 Cremation

Physician/ Medical **Examiner** 

Department of Health a Important: If item 27 is any injury or other traconce.

Physician/ , Medical

**Examiner** 

10a. State

Director

Funeral

Completed by

Be မ

**Funeral** Director

iral", or items 23a or 28a-f show Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important if fleat 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

the Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Certificate

Exar	
Medical	
To Be Completed by Physician/Medical	1
d by F	
Completed	
Be	2
2	,

Medical

29a. Certifier

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jarko

4 Donation 5 Other (Specify)	LEDAR /4	14- 7-	3-12- 62	EN DURNIE /1/V,	
21. Signature of Funeral Service License	22.1	Name and Address of Facility 2	70 FREDNIL	TOT COSS BATT, MID,	
Xmus It IT W	VI GA	BY P. MARCH FULL	MRA HOME	-Y./+ 21229	_
23a. Part 1. Enter the disease, or compli shock of heart failure. List only one	cations that caused the death. Do not enter cause on each line.	the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between	
Immediate Cause (Final disease or condition resulting in death)	Due to r as a consequence of):			Onset and Death	4
Sequentially list conditions,	Due to VT as a consequence of.				
if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
that initiated events resulting in death) Last	Due to (or as a consequence of):				_
					_
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
Part II. Other significant conditions cor	ributing to death but not resulting in the und	derlying cause given in Part I.		o use contribute to the cause of death? 2 12 No 3 D Probably 4 D Unknown	n
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  No. 1 \( \text{Yes} \) 2 \( \text{No} \) No	
25. Was case referred to medical examiner?		26. Place of Death (Che			
1 ☐ Yes 2 ☑ No	ospital:	3 DOA Other: 4 Nursing H	lome 5 Residence	6 ☐ Other (Specify)	
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury 28b. Time of (Month, Day, Year) injury	28c. Injury at work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	t, factory, office	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)	
					_

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the pasis of examination and investigation, army symbol, accurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 06-2011

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Eloise Evans 1254 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore University of Maryland Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 239-66-2905 Director 1 □ M 2 🗓 F NORTH CAROLINA 69 DEC 7, 1942 Usual Residence of Decedent of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 No MARYLAND HARTFORD **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 1469 HARFORD SQUARE DRIVE 21040 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) CHILD CARE PROVIDER PRIVATE 12 and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed in Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JESSIE JAMES REEVES MARSHMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANGELA E. HUDGENS / DAUGHTER 1469 HARFORD SQUARE DRIVE, EDGEWOOD, MARYLAND 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) OLIVET CEMETERY 07/02/2012 WASHINGTON, DC Signature of Funeral Service Licensee 22. Name and Address of Facility JB JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD, HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Pulmonary Hypertension
Due to (or as a consequence of): Medical resulting in death) **Examiner** Premonia weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): 3 weeks Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit Ventilator-dependent respiratory that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical End-stage rend disease 6 years Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Coronary arkey disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Diameters Mellitus type ? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 25. Was case referred to medical Be Division of Vital 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DDA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred To the Funeral Director: After completely filled in by the funer 1 Natural 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 110418 2658 Jun 27, 2012 MO 30. Name and addrees of person who completed cause of death (Item 23a) (Type, Print) 225. Greane St, Baltimore MD 21201 Adam Jasne MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 29 2012 A. Jane

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrer	State	of Marylai		artment of H		nd Mental	Hygier	7111	2 20731	
			Decedent's Name (First, Midd.	le, Last)				- Cat		of Death		3. Time of Death	
	Physici /Medic		Elizabeth Corr		Monti Jur	ne 26, 2012		11:50 P M					
	Examin		4a. Facility Name (If not institution	n, give street and ne	umber)		4b. City, Town, or	Location of			4c. County of De		
			Charlestown (				Catons				Ва	1timore	
В	Funeral Director		5. Social Security Number 212–16–8380	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. 92	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Mont	of Birth h, Day, Yea 16,1	ar)	Birthplace (State or Foreign Country)	
	σ		Usual Residence of Decedent						reb.	10,1	1920 F18	iryrand	
	anylar show	_	10a. State 10b. County	altimore	10c. C	ity, Town or Lo						10d. Inside City Limits	
	28a-f	Director	MD Ba	altimore		Caton	sville			10-	Citizen of What	1 Tyes 2 No	
	3a or	ä	709 Maiden Cho	oice Lane	RG204S		10f. Zip Code 2122	28			JSA	Country?	
	deeth	Funerai	11. Marital Status		edent Ever in l		Was Decedent of H	ispanic Origi	n? (Specify Yes	or No-		merican Indian,	
39	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygisne. Is marked other than "natural", or flems 23s or 28s-f show aumatic event, the Medical Examinar must be notified at	by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	ried 1 ☐ Yes	2 🔯 No ive		f Yes, specify Cuba 1 □ Yes 2 ☑ No	Specify:	Риепо нісап, ет	5.}	Specify: W		
ည်	72 hou	Completed	15. Deceder	nt's Education	Education 16a. Dec			edent's Usual Occupation			Kind of Busine	ss/Industry	
7	nthin nen nen	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			ve kind of work done during most of working . DO NOT use retired)						
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Maryland 21215-0036	id be f ental k ked of ic eve	To Be	Wilbert F. Ro						Evelyn F		,		
ary	shou and M mar		19a. Informant's Name/Relations				ng Address (Street	and Number	or Rural Route N	lumber, Cit	y or Town, State		
	es 1 and 2 should b of Heelth and Ment litem 27 is marked r other traumatice		Alice Jayne Va	anderwaar	and the same of			Avenu		-			
altimore,	Pages 1 sent of H nt: If ite ry or oth		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (5)		State	cemetery, crer	sition (Name of natory or other plac .rk Cemete		Date /2/2012		Location - City Ltimore,		
Balti	permit. Pages 1 Depertment of H important: if ite any injury or oti once.		21. Signature of Funeral Service	Licensee Mal	124	22 F	Name and Addres	ss of Facility	Sterling Catons	Asht	on Schw	ab Witzke	
			23a. Part1. Enter the disease, o	r complications that	caused the dea						18V111e,	MD 21228 Approximate	
	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	t only one cause on	each ane.	P	emen	tra				Interval Between Onset and Death	
1	/Medical Examiner		resulting in death)	Due to	(or as a conse		110.1						
	LAdillilici	<u>.</u>	Sequentially list conditions,	b. — Due to	or as a conse	Supres of							
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	quence on									
ó	execuen and and rial-tra		that initiated events resulting in death) Last	C. Due to	(or as a conse	quence of):							
8760,	cate be executed bhysicien and the burial-transIt	dical		d									
9	ertification plant		IF FEMALE:	22- 14									
Вох	it the death certiff by the attending tached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregr birth 2 ☐ Fet mant at time of	al death 3	Ectopic pregnancy Other (specify)				23d. Date of Month	delivery Day Year	
0	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unki		304.11							
s, P	res tha igned be det	by P	Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying cause give	en in Part I.	23e.	Did tobacc	o use contribute	to the cause of death?	
ord	w require been sig should b			li	ing		spell			1 Tes	2 12√√√0 3 □	Probably 4 Unknown	
Records,	2 8 a	Completed			V				24a.	Was an autopsy performed	24b. Were prior death	autopsy findings available completion of cause of	
	itcien: The certificate hi		25. Was case referred to medical	N. C.						res 20		es 2□No	
5	ysicie is cert direct	To Be	examiner?	Hospital	Inpatient 2	☐ ER/Outpatien	t 3 DOA Othe		of Death Check		€ □Othor (6	Page Mal	
0	iding Phys th. : After this funeral di		27. Manner of Death	28a. Date		28b. Time of					njury occurred	рөспу)	
Sio	r Attendir er death. rector: Al by the fu	catic		igation	,,,	,,		Yes 2 □ No	0				
Division of	of or Attended the first of the death of the clor:	Certification:	4 Homicide determ	ningal 289. Plac	e of Injury - At I ding, etc. <i>(Spec</i>	nome, farm, str ify)	eet, factory, office			tion (Street or Town, St		Rural Route Number,	
	To the Hospitel or Attending Physicien: within 24 hours elter death. To the Funeral Director: After this certifica completely illed in by the funeral director.	Medicai C	29a. Certifier 1. Certifyi (Check only one) 2 Medical	ng Physicien: To the	e best of my kn basis of examin	owledge, death ation and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to occurred at the	o the cause time, date a	e(s) and manner and place, and c	as stated. due to the cause(s)	
	o the	Me	29b. Signature and title of certifit		A		29c. License	e number		29d.	Date signed,(Mo	onth, Day, Year)	
	/		•	VCa	N	MA	D.	CC 28	140		6/2	7/12	
	Com		30. Name and address of person	who completed cau	use of death (Ite	om 23a) (Typę.	Print)	kon	06	CEAR	, Co	a Guarilla	
i. K	Sta Registr	-	31. Date filed (Month, Day, Year JUN 2 9 201)		Registrar's Sign	Sark	,				,	MI	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June 2012 4:15 Dorothy Chriscoe Ewbank Ам Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number Funeral 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours (Month, Day, Year) Min. Director 533-14-0922 1 □ M 2 🔀 F 89 Apr 23, 1923 Washington ir then "neturel", or items 23e or 28e-f show the Wedical Examinar must be notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 627 Azalea Drive #1 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 K Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 4 Administrator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked o 2 should be Carson Chriscoe Sadie McNeill . Page 1 end 2 should tment of Health and N tent: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Chrisco Andrews / Niece 3309 Macomb St. NW Washington. DC 20008 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Importent: If its any Injury or of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 6/29/2012 Woodbine, Maryland Signature of Funeral Service License Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Cerebrovascular Accident Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of). signed by the ettending physician and defached for use es the buriel-transit To the Hospitel or Attending Physicien: The lew requires that the death certificate be executed within 24 hours after death.

To the Funerei Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🕱 No 4 Pregnant
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 2 🛣 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\boxtimes$  Other (Specify) HOSpice 1 ☐ Yes 2 🗷 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signatura and title of certifie 29d. Date signed (Month, Day, Year) 6.28.12 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller 6001 Muncaster Mill Rd. Rockville, MD 20855

Registrar

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elgin Fernneta Μ. 8:15 201 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Nursing Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F (Month, Day, Year)
March 11, 1915 96 Months Days Hours 214-46-7897 Maryland Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director N/A Baltimore 1 X Yes 2 □ No Maryland 10f. Zip Code 10e. Street and Number 0 10g. Citizen of What Country? items 23a Funeral 21239 United States of America 1651 E. Belvedere Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 5 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 ▼ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hyglene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be Page 1 and 2 should be filed went of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anna Ortman Roy B. Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 957 E. Macphail Road Bel Air, MD 21015 Clifford Elgin-Son other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State July Date 03. permit. Page 1 Department of Important: If it any injury or o Evan's Funeral Chapel – Bel Air ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, MD 2012 4 Donation 5 Other (Specify) re of Funeral Service Licenses 22. Name and Address of Eacility Evans Funeral Chapel & Cremation Services 8800 Harford Road, Parkville, MD 21234 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final lease or condition Physician/ POXIA Medical resulting in death) **Examiner** Iweek Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an perform death? Yes XX No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: XX Nursing Home 5 - Residence 6 - Other (Specify) 2 🔀 No 1 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred

or Attending Physician; The law requires that the death certificate be Box 68760 P.O. Division of Vital Records,

24 hours after death Funeral Director: filled in by

27. Manner of Death

only one)

29b. Signature and title of certifie

1X Natural 5 Pending Investigation Accident Suicide 4 Homicide

6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work? 1 ☐ Yes 2 ☐ No

June 28,2012

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Jeont 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Luch Raven Blvd. Baltimore MD 21239 Thomas Wilson V 31. Date filed (Month, Day, Year)

State Registrar

completed within 2

Medical

2.9 2012



DHMH 17 Rev 7/2009

iniury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Elizabeth Foster Medical Tune 2012 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 218-44-7283 Director 1 □ M 2 🗷 F 64 03/03/1948 Maryland Usual Residence of Deced 10a. State 10c. City, Town or Location notified at Funeral Director 28a-f Maryland Baltimore Overlea the 1 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? must be 23a 6116 Belair Road 21206 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. 0 þ 1 Never Married 2 Married Yes 2 X No ト25 ナヒィ エフスのした Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔽 No Specify: Specify: White Completed 3 🖫 Widowed 4 🗆 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiens Important: If item 27 is marked other than 'any injury or other traumatic event, the Merone. Elementary/Secondary (0-12) College (1-4 or 5+) Steel Worker Steel Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Creech Mary Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Chris Foster Son 528 Kearney Street El Cerrito, California 94530 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 6-29-12 ArdentCremationOfMD Hanover, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 6009 Harford Road Baltimore, Maryland 21214 michael maruel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Ination Medical Examiner ptroblin Secure tially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (o s a conseque ce of): burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 X No 1 ☐ Yes 2 🔀 9 ☐ Unknown the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dysphagia. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 X No. 1 Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

2:45AM

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Dav

Year

1 Yes 2 No

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has

> State Registrar

filled in by the

Certificate:

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANTOSH DHITAL. GOOD Samoritan Hospital of Maryland. 5601 Loch Raven Blud
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SANTOSH DHITAL. GOOD Samoritan Hospital of Maryland. 5601 Loch Raven Blud 31. Date filed (Month, Day, Year)

2 💢 No

3 🗆

29b. Signature and title of certifier

5 Pendina

Investigation 6 Could not be

determined

27. Manner of Death

1 🔀 Natural

2 Accident
3 Suicide

4 Homicide

29a Certifier

(Check

Hospital

28a. Date of injury (Month, Day, Year)

1 X Inpatient 2 - ER/Outpatient 3 - DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

injury

1 ZC critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Other:

28c. Injury at work?
1 Yes 2 No

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RESODO

4 Nursing Home 5 Residence 6 Other (Specify,

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

JUNC, 23, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #23a&b Per PHY G928 6/29/2012 JH
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 06/11/2012 10:50 a.M Fowler Lee Dawes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Examiner Queen Anne's Hospice of Queen Anne's Centreville . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours Min. 88 240-26-5777 Director 1 M 2 X F 06/17/1923 North Carolina Usual Residence of Decedent 28a-f shov 10h County 10c. City, Town or Location 10d Inside City Limits 10a State Examiner must be notified at Director MD Talbot Wye Mills 1 Yes 2 X No 10f Zip Code ō 10e. Street and Number 10a, Citizen of What Country? items 23a Funeral United States 21679 13485 Rustling Oaks Dr. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. or 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😿 No Specify. If Yes, Give Year or Dates Specify: White "natural", 3 → Widowed 4 □ Divorced Completed event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working marked other than life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file nent of Health and Mental I ant: If item 27 is marked o Stancil ဂ္ Devonia Alice John Wells Dawes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13485 Rustling Oak Dr. Wye Mills, MD 21679 Patricia Ann Whalen (daughter) 20b. Place of Disposition (Name of 20a Method of Disposition June Date 12, 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State ö Bethesda, Maryland Uniform Services Univ. 2012 5 Other (Specify) any injury 4xxDonation 22. Name and Address of Facility Rapp Funeral & Cremation Service 21. Signature of Fune I Service Licensee ms 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Congestive Heart Failure Interval Between Immediate Cause (Final Onset and Death Physician/ Y247 disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Coronary Artery Disease Sequentially list conditions. in any, reading to increase cause. Enter Underlying Cause (Disease or injury Examine Due to for as a nonsequence of as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 use a 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🙀 No
9 ☐ Unknown Month ģ Year Pregnant at time of death 5 Other (specify) detached 9 Unknown the P.O. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director: After this certificate has b autopsy page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No LENTON Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year) 6374 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Contreille JEFFRE UXENY 2540 31. Date filed (Month, Day, Year) 32. Registrar's gnature State JUN 29 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MILDRED FREY 2012 JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death FOREST HILL Examiner 4c. County of Death HARFORD SENATOR BOB HOOPER Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months Davs Hours 140-14-4350 102 1 □ M 2 F **Director** 12/24/1909 NJUsual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show eny injury or other treumatic event, the Medical Evaniner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director HARFORD 1 Yes 2 No BEL AIR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1210 STARMOUNT LANE Funeral 21015 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give 3 Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 2102,23 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES VOGEL CATHERINE DITZEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 STARMOUNT LANE BEL AIR, MD 21015 KATHRYN MURPHY-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ATLANTIC CREMATORY 6/27/12 GLEN BURNIE, MD 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR Signature of Funeral Service Licensee BEL AIR, MD 21014 610 W. MACPHAIL RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physicien and I for use as the burlai-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate hes been si al director, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The lew within 24 bours after death.
To the Funerel Director: After this certificate hes t completely filled in by the funeral director, pege 2 s autopsy 2 200 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence မ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Sperify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and titi 29d. Date signed (Month, Day, Year) IDAN 31. Date filed (Month, Day, Year)
JUN 29 2012 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma	aryland			lealth and M	1ental Hy	giene	0 00707		
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of E	Death	2, Date of De	Reg. No.	3. Time of Death		
	Physicia Medic		Joseph Car	rol1	Fishe	er		June 2				
	Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death  14316 Oakvale Street  Rockville							4c. County of Death Montgomery		
	Funeral	W.	5. Social Security Number 6. Sex 7. Age	e (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th 9. E	Birthplace (State or Foreign		
E	Director		217-42-1121 1 M 2 G F	70	Yrs.	Months Days	Hours Min.	April I	, 1942 Was	Shington, D.C.		
	and show at	'n	Usual Residence of Decedent  10a. State 10b. County	10c. City, T	Town or Lo	cation				10d. Inside City Limits		
	Maryla 28a-f ptified	rect	Maryland Montgomery	i		Rockville	<u>.                                    </u>			1 ☐ Yes 2 🔀 No		
	with the s 23a or sust be n	Funeral Director	10e. Street and Number 14316 Oakvale Street			10f. Zip Code 2085	3		10g. Citizen of What C United St			
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once,	Completed by Fur	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 ☒ Yes 2 □ If Yes, Give Year or Dates. 1	No	'	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛣 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify;	nerican Indian, nite, etc. White		
2-0	2 hour "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)		16a. Dece	dent's Usual Occupa	ation during most of worki	'ng	16b. Kind of Busines	s Industry		
121	ithin 7 ene. r <b>than</b> the Me	Com	Elementary/Seconday (0-12) College (1-4 or 5	+)	life. DO NOT use retired)  Hospital Administrator			•	Health (	h Care		
	illed wall Hyging I othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surname)			
ylaı	Ild be Menta narked	욘	Carroll Fisher				Marie M					
, Maryland	nd 2 shou ealth and n 27 is n		19a. Informant's Name/Relationship (Type, Print)  Louise J. Fisher/Wife						er, City or Town, State, 2 e, Marylan			
Baltimore,	Page 1 al tment of H <b>tant: If ite</b> jury or oth		20a. Method of Disposition  1   Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Plac Gat	ce of Disponence of Disponence of Cemet	sition (Name of natory or other plac Heaven Lerv	June 20	e 29, 12	20c. Location - City	or Town, State ing, Maryland		
Ball	Depart Impor any in		21. Signature of Funeral Service Licensee	м0019	8 R 30	Name and Address bert A. P O West Mor	s of Facility umphrey Intgomery	Funeral Ave., Ro	Home/Rocky	ville, Inc. aryland 20850		
-	Physician/		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Lewy I	·.			g, such as cardiac c	or respiratory ar	rest,	Approximate Interval Between Onset and Death 4 Years		
	Medical Examiner		resulting in death)  Due to (or as a	consequen	nce of):							
	d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	1 consequer	nce of):							
	cate be executed physician and s the burial-transit	Exar	that initiated events resulting in death) Last C. Due to (or as a	a consequer	nce of):							
09	te be e nysicia ne buri	dical	d									
987	ertifical		IF FEMALE: 23c. If yes, outcome	of pregnanc	V							
P.O. Box 687	ne death certific y the attending p ched for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1	2 Fetal d	leath 3	Ectopic pregnand Other (specify)	ey		23d. Date of o	Day Year		
ls, P.0	requires that the des been signed by the s should be detached	ed by P	Part II. Other significant conditions contributing to death b	ut not result	ing in the u	ınderlying cause giv	ven in Part I.		I tobacco use contribute to the cause of death?  Yes 2 🖾 No 3 🗆 Probably 4 🗀 Unknown			
Division of Vital Records,	× 85 ×	Completed by						24a. Was auto perfo 1 \sum Yes	psy prior to prior to death	autopsy findings available o completion of cause of ? Yes 2 \( \sum \) No		
tal	cian: T	Be C	25. Was case referred to medical examiner? [Hospital:				ace of Death (Check			_		
Ž	Physia this c	은	1 ☐ Yes 2 ☒ No 1 ☐ Inpatie  27. Manner of Death 28a. Date of inju		R/Outpatier 8b. Time of	ont 3 DOA Other	4 L Nursing Ho		dence 6 Other (Sp.	ecify)		
0 U	ath. : After e funel	cate	1 🛣 Natural 5 ☐ Pending (Month, Day 2 ☐ Accident Investigation		injury	work		zad. Describe i	low injury occurred			
Division	al or Attending Physician: The la s after death. I Director: After this certificate ha d in by the funeral director, page.	Certificate:	3 Suicide 6 Could not be		e, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and Number or Rural Route Number, vn, State)			
_	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	29a. Certifier  1  Certifying Physician: To the best of 2  Medical Examiner: On the basis of examiner only one)  1 Certifying Nurse Practions 1  1 Certifying Nurse Practions 2  1 Certifying Nurse Practions 3  1 Certifying Nurse Practions 3  1 Certifying Nurse Practions 3  1 Certifying Nurse Practions 4  1 Certifying Nurse Practions 5  1 Certifying Nurse Practions 5  1 Certifying Nurse Practions 5  1 Certifying Physician: To the best of 2  1 Certifying Physician 5  2	xamination a	nd/or inves	tigation, in my opinio	on, death occurred at	t the time, date a	and place, and due to th	e cause(s) and manner stated.		
	To th withii To th	7	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mor	nth, Day, Year)		
ンと	\		30 Name and address of person who completed cause of d Thomas J. McNamara, M.D.	eath (Item 20			, #100. R	ethesda	. Maryland	20817		
	Stat Registra		1. Date filed (Month, Day, Year) 62. Registre	ar's Signatur			,,					
			THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAM	100	100							

DHMH 17 Rev 7/2009

ne Ann Fe	aga	ns State of Maryland					gible.	201	0 007	
		1- For State Registrar	Certificat	e of Death		Re	g. No.	ZU 1	2 207	
Physici ical Exam	ian/ iner	Decedent's Name (First, Middle,Last)  Darlene  Ann	Foar	zanc		2. Date of Deat Month	Day	Year	3. Time of Death 1458 hrs	
		4a. Facility Name (if not institution, give street and number)	Feag		Location of Death	June 25, 2		ounty of Deat		
		7514 Holabird Avenue		Dundalk			Ва	Itimore Co	unty	
Funeral Director		210 64 4205	e (In yrs. last birthda	ay) If Under 1 Yea Months Day				Forei	rthplace (State or	
Director		218-64-4305 1 N 2 X F Usual Residence of Decedent	58	Yrs.	110010	Februar	y 11 <b>,</b>	1954 c	ountry) Marylar	
any		10a. State 10b. County	10c. City, Town or I	Location					10d. Inside City Limits	
and show	5	Maryland Baltimore		Dundalk					1 Yes 2 XN	
Maryland r 28a-f show	Director	10e. Street and Number 7514 Holabird Avenue		10f. Zip Code	24.200	10	Og. Citizer	n of What Cou	intry?	
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once				21222			USA			
eath w items ust be	Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?	·	<ol><li>Was Decedent of His If Yes, specify Cubar</li></ol>	spanic Origin? ( Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14	Race - Amer White, etc.	rican Indian, Black,	
ther do	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:	X No	1 Yes 2 X No	specify:		Sp	pecify: Wh	ite	
hours a		15. Decedent's Education (Specify only highest grade con	duri	cedent's Usual Occupa	tion (Give kind of v	work done	16b. Kin	d of Business	Industry	
uld be filed within 72 l Mental Hygiene. marked other than ", e event, the Medical E	plet	Elementary/Secondary (0-12) College (1-4 or 1)	5+)	ental Assis		190)	,	Dontie	iatas	
gier ber	Completed	17. Father's Name (First, Middle, Last)				other's Name (First, Middle, Maiden Surname)			istry	
be file ntal H rked c	Be	George Fazzuoli				Juarasc		,		
permit. Pages I and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked of injury or other traumatic event, the	2	19a. Informant's Name/Relationship (Type, Print )		Mailing Address (Stree					e, Zip Code)	
and 2 s ealth a cm 27	- 3	Ken Feagans Husband  20a. Method of Disposition		2 Cape May				and 21 sation - City or	221	
permit. Pages l ar Department of Hec Important: If ite		1 Burial 2 X Cremation 3 Removal from Sta	crematory	or other place)		ne 29,				
artmen ortant ry or		4 Donation 5 Other Specify: 21. Signature of Funeral Service U cery ee		Crematory  22 Name and Address		2012			Maryland	
Dep Dep			101176	22 Name and Address Connelly F 7110 Solle	uneral H	ome Of I	ounda	alk,P.A	21222	
hysician	- 1	23a. Pert I. Enter the disease, or complications that caused failure. List only one cause on each line.	the death. Do not er	nter the mode of dying,	such as cardiac o	r respiratory arre	st, shock	or heart	Approximate Interv	
Medical xaminer		Immediate Cause (Final disease a. Morphine		ion					Between Onset and Death	
		or condition resulting in death)  Due to (or as a conse	iquence of):							
	miner	Sequentially list conditions, if any, leading to immediate  Due to (or as a conse	equence of):							
- 1/4	ami	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conse	equence of);				_	_		
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death certificate be the attending physici of for use as the buri	Physician/Med	IF FEMALE: 23c. If yes, outcom 1 Live birth	ne of pregnancy	Fetal death 3	Ectopic pregna	ncv		ate of deliver	y Day Year	
eath certific attending p for use as th	sicia	past 12 months?	time of death 5	Other (Specify)		iley		JIIII 1	Jay Teal	
t the deg by the a ached fo	Phys		huk ant and direction			Lon- pill		7.0		
ires that signed b	ā	Tack. Other significant conditions	but not resulting in	the underlying cause g	iven in Part I.				the cause of death?	
require seen si ould b	Completed					24a. Was a			itopsy findings availab	
e law i e has l ge 2 sh	Ē					autops perform	y ned?	prior to death?	completion of cause of	
cian: The certificate ector, page		25. Was case referred to medical	·	26.Place	of Death (Check of	1 Yes 2	∐_No	1 🗸 Ye	es 2 No	
hysicia this ce I direc	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpa		Other Nursin		Residence	6 🗸 Other	: Scene	
After After funera	٤	27. Manner of Death  1 Natural 5 Page 16 Natural 28a. Date of Injur (Month, Day, Ye	y 28b. Time	e of Injury 28c. Injur	y at Work?	28d. Describe ho				
Attend death ector:	catic	2 Accident Pending Investigation Fd 6-25-		: ЭU РШ   —		unknown				
28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R or Town, State) 7514 Hold								Number or Ru 14 Hola	ral Route Number, City <b>bird Ave.</b>	
Hospid 24 hour Funer rely fill		4 Homicide Getermined (Specify) 10  29a. Certifier (Check only)  Certifying Physician: To the best of my			te and place, and	Dundalk		anner as state	ed.	
To the Hos within 24 h To the Fus completely	Medical	one) 2 Medical Examiner: On the basis of exam	nination and/or inves	stigation, in my opinion	death occurred a	t the time, date a	nd place,	and due to th	e cause(s)	
C 4 F 3	ž	29b. Signature and title of certifier		29c. License	number		29d. Date	e signed (Mo	nth, Day, Year)	
		tan U- Tolla		O.C.	И.E.		June 2	26, 2012		
		<ol> <li>Name and address of person who completed cause of de Patricia Aronica-Pollak MD. Assistant M</li> </ol>	,	er 900 W. Baltin	ore Street P	altimore MD	21222			
			's Signatur	JI JOU VV. DAILIII	iole Stieet, B	aillinoie, MD	Z 1223			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month James 3:28PM Golson ، ک 2012 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Samariten Baltmore Baltmar 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 1**x** M 2 □ F May 31, 1962 Maryland 50 Usual Residence of Decede or 28a-f show 10a. State must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 4455 Wrenwood Avenue 21212 USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", 1 ☐ Yes 2 💢 No Specify: black Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk (Specify only highest grade completed) if Health and Mental Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) 12 laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be william Hudson Joyce Golson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Kennedy/cousin 4535 Shamrock Avenue Baltimore, MD Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it tment of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 X Other (Specify) in state Signature 1 Funeral Service Licens 20 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Diabek Medical resulting in death) Examiner Sequentially list conditions Examine Due to for as a consequence of, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Pregnant at time of death Day Year 2 No q Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autops perform? filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Matural work?
1 Yes within 24 hours after death To the Funeral Director: A Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TIEM#1perpHYS, G929, 7/1672012, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, I Grabowski 2. Date of Death 3. Time of Death Physician/ Month 1000 Ca TUDOL Medical 7225 201 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis <u>Anne</u> Arunde1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director 218-18-0981 1 □ M 2 💢 F 89 Usual Residence of Decedent July 22, 1922 Maryland Maryland show at 10c. City. Town or Location Director 10d. Inside City Limits be notified 28a-f s MD Anne Arundel 1 🗆 Yes 2 🔀 No Odenton 10e. Street and Number 23a or 10f. Zip Code 10g, Citizen of What Country? Completed by Funeral "natural", or items 23a 2605 Clarion Court 21113 USA and 2 should be filed within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ▼ No Specify: 3 Divorced 4 Divorced Specify: white marked other than "natu matic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. toll collector state of MD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Health and Mentitem 27 is marked the traumatic e Joseph Martin Guldan Amalia Hodulik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Wilhelm/daughter other 1 2605 Clarion Court Odenton, MD 21113 tem Important: If iten any injury or othe once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Page 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Ronald & State Anatomy Board Baltimore, MD 21201 Wade, Pirector 655 W. Baltimore Street Baltimore, MĎ 23a. Pal. 1. Enter the dise see, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.

Immediate use (Final Approximate interval Between Onset and Death Physician/ awo disease or condition Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events burial-tran and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Vear signed by the at I be detached for Yes 2 No 9 Unknown 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 2 🗌 No 1 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Director; After Hospital or Attending Natural 5 Pending injury after death. Accident Suicide Investigation M 2 🗌 No filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Less ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Contifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number (Month, Day, Year) 29d. Date signed Drite 00 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 200 NUD sell 0 31. Date iled (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 21, 2012 Bruce Michael Gordon, Sr. 11:00 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 137 3RD Ave. Lansdowne Baltimore 5. Social Security Numbe Sex 1 M 2 F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Country) New York 8. Date of Birth **Funeral** Days Hours Min. April 26, 1941 Director 124-30-4860 71 Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b County notified at 10c. City, Town or Location 10d. Inside City Limits Director MarylandBaltimore 1 Yes 2 🗓 🗖 Lansdowne ō 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country's Examiner must be Funeral items 23a 21227 137 3RD Ave. United States hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Armed Forces Black, White, etc. ò þ 1 Never Married 2 X Married 2 . No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify White 'natural", Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be flied with Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other transmitted. 10th N/A Baker Culinary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Charles Gordon Genevieve Marion Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow Vivian Gordon / Wife 137 3RD Ave., Lansdowne, Maryland 21227 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State oudon Park Cemetery June 26,201 Baltimore, Maryland 4 Donation 5 Other (Specify) ign ture of Fa ral Service Licensee 22. Name and Address of FaciliAMBROSE FUNERAL HOME OF LANSDOWNE Hammonds Ferry Rd., Lansdowne, Maryland 21227 719 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician HE 0 disease or condition Months Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the phy nding p IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ for in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by To the Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 27 No Hospital Other: 1 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Naturai 5 Pending iniurv work?
1 Yes 2 No s after death.

I Director: Aff
d in by the fur Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completed fi 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

DHMH 17 Rev 7/2009

29b. Signaty and title of cert

31. Date filed (Month, Day, Year

d address of person who completed cause of death (Item 23a) (Type, Print)

UN 1314

821

29c. License number 72907

57 #305 BAGIMUNEMOHO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 6 Noelle Anna Greenzaid Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Manorcare Health Services Potomac Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number **Funeral** Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Davs Hours 127-28-9166 Director 80 1 □ M 2 🕅 F 12-25-1931 Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location Director must be notified at MD Montgomery Bethesda 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7500 Leesburg Place 20817 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes Give Specify: 3 Widowed 4 XDivorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Abraham Ehrenberg Frieda Berger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Greenzaid 9825 Carmelita Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garden of Remembrance 6-29-2012 22. Name and Address of Facility Edward Sagel Funeral Direction . Signature of Funeral Service Licensee Brad Smetzer 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Atherosclerotic Vascular Disease Sequentially list conditions, Examiner as a consectiving of cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descent at time of death 5 Other (specify) IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 XNo 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records. Was a. autopsy performed? 24a, Was an Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? injury 1 XNatural 5 Pending Accident Suicide Investigation 1 Ves 2 No after death filled in by the

20c. Location - City or Town, State Clarksburg, Maryland Interval Between Onset and Death 23d. Date of delivery Month Day Vear 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🛛 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 🚨 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 6-28-2012 Thomas Masterson, MD - 1390 Chain Bridge Road, #900, Mclean, Virginia 22101

2012

Black, White, etc.

5:00

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 🔲 Yes 2 🗓 No

France

White

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State Registrar

24 hours a

within 2 To the I

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Medical

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 Homicide

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

10mas

JUN 29 2012

29a. Certifier

DHMH 17 Rev 06-2011

29c. License number

D50534

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Susana Gomez Month Jun 27, 2012 3:25 PM M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice of Howard County Columbia Howard 8. Date of Birth (Month, Day, Year) Mar 2, 1930 7. Age (In yrs. last birthday) **82** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Spain 150-48-5932 Hours Spain 1 □ M 2 X F Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard Columbia, MD 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10065 Windstream Drive 21044 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give White 1 ■Yes 2 No Specify: SPANISH 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) **Homemaker** 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Domestic** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Miguel Diaz Maria Unknown 19a. Informant's Name/Relationship (Type, Print)
Philip Gomez 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10065 Windstream Drive Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
St. Louis Cemetery Jul 02, 2012 Clarksville, MD 4 Donation 5 Other (Specify 22. Nam Stack Firmer and Mome, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 unatur 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line

**Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physici Division of Vital Records, P.O. Box 68760 within 24 ho

To the Fune

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Physician/

Medical

Director

Funeral

Completed by

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**Examiner** 

**Funeral** 

**Director** 

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an "natural", or items Medical Examiner mu

with the Maryland

permit. Page 1 and 2 should be filed within 72 hours after death

nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me

Department of Important: If it any injury or o

Physician/ Medical

ig physician and as the burial-transit

nse for ed by the a

s been signed to should be det

s certificate has director, page 2

filled in by the funeral dir

Baltimore, Maryland 21215-0036

	Immediate Cause (Final disease or condition resulting in death)	a STROKE				Onset and Death					
Examiner	Due to (or as a consequence of):  DEMENTIA  Due to (or as a consequence of):  DEMENTIA  Due to (or as a consequence of):  DEMENTIA  Due to (or as a consequence of):  CORONARY ARTERY DISEASE										
edical Ex	resulting in death) Last										
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23d. Date of de Month	livery Day Year								
ted by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  1 □ Yes 2 ② No 3 □										
Completed				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of					
Be	25. Was case referred to medical		26. Place of Death (Check	only one)							
ျ	I L Yes 2 Z No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Ho	me 5 Residence	6 🗷 Other (Spec	ity) HOSPICE					
Medical Certificate:	27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation 3  Suicide 6  Could not be		28c. Injury at work?	28d. Describe how inju							
al Cert	4 Homicide determined	28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	actory, office	28f. Location (Street a City or Town, Stai	nd Number or Rural Route Number, te)						
Medica	(Check 2 L Medical Examin	sician: To the best of my knowledge, death occurring: On the basis of examination and/or investigationse Practitioner: To the best of my knowledge, death	n, in my opinion, death occurred at	the time, date and place	e, and due to the	cause(s) and manner stated.					
	29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Month	n, Day, Year)					

P R047324 JWEZ7, 2012 6. Print) 6336 CedarLANE, Columbia, MD 21044

10

State Registrar

Date filed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Man		rtment of F		Лental Ну	giene 2011	2 20744			
			Registrar  1. Decedent's Name (First, Middle,	Reg. No.	3. Time of Death								
	Physicia Medi		Nathaniel		G	Month	Day_ Year	, 7 6					
	Examir	ner	4a. Facility Name (if not institution,	*		4b. City, Town, or			4c. County of Dear	th			
	Funeral		The Johns  5. Social Security Number  216-62-2188		yrs. last birthday)	Buting I Year	If Under 24 Hrs.	8. Date of Birt	N/A	thplace (State or Foreign			
	Director		216-62-2188 Usual Residence of Decedent	1 □ <b>x</b> M 2 □ F	59 Yrs.	Months Days	Hours Min.	01/16	/1953 Mar	yland			
	rland f shov d at	ţ	10a. State 10b. County	10	c. City, Town or Loc			I.		10d. Inside City Limits			
	e Man r 28a- notifie	Sire	MD N/A		Balt:	imore				1X Yes 2 □ No			
	h with th	Funeral Director	727Druid Park	Lake Dr. A	pt 3I	10f. Zip Code	21217		10g. Citizen of What Co	ountry?			
9800	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  1 → Never Married 2 □ Marri 3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates.	If	as Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B1	e, etc.			
21215-0036	within 72 ho giene. er than "na er the Medic	Completed	15. Decedent (Specify only highes 12th Grade	's Education t grade completed)  College (1-4 or 5+)	(Give ki	ent's Usual Occupa nd of work done do NOT use retired) todian	ition uring most of worki	ing	16b. Kind of Business/	,			
Maryland	ould be filed within 7; id Mental Hygiene. marked other than matic event, the Me	To Be	17. Father's Name (First, Middle, Le Nathaniel Gre				18. Mother's Name Ethel I	e (First, Middle, I Mae Wh	Maiden Sumame) ite				
	1 and 2 should of Health and Me item 27 is mar other traumati		19a. Informant's Name/Relationshi	(friend)	1800	Hollin	nd Number or Rura s St. A	Route Number, pt 425	City or Town, State, Zip W, Balti	more, MD			
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		20a. Method of Disposition  1 ☐ Burial 2 🔀 Cremation  4 ☐ Donation 5 ☐ Other (Sp.	B Removal from State	20b. Place of Dispos cemetery, crema on-site	atory or other place	)	Date IK ]	20c. Location - City or Baltimore				
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service Lie	Leane	2	Sephodia 140 N. 1	of Brown	Jr. F	uneal Hom Baltimore	e PA , MD 21217			
	Physician/ Medical		23a Part 1. Enter the disease, or of shock, or learn failure. List on line disease or condition resulting in death)	omplications that caused the ly one cause on each line.  SEPSI  Due to (or as a core	S	the mode of dying	, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death			
	Examiner	er	Sequentially list conditions,	b									
	cuted nd transit	kamin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor									
09	ate be executed physician and the burial-transit	dical Examine	resulting in death) Last	Due to (or as a cor	nsequence of):								
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	ıysician/Med	Me	ysician/Medi	ıysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pr  1  Live Birth 2  4  Pregnant at time 9  Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ls, P.O.	uires that t n slgned b uld be deta	ρ	Part II. Other significant condition	s contributing to death but no	ot resulting in the und	derlying cause give	n in Part I.	23e. Did tob	pacco use contribute to	the cause of death?			
Division of Vital Records,	The law rec ate has bee page 2 sho	Completed						24a. Was ar autops perforr 1 Yes 2	y prior to c ned? death?	opsy findings available ompletion of cause of			
ta	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			ce of Death (Check		ZACINO TELIES	2 L NO			
Ž	Physical this caral dir	일	1 ☐ Yes 2 🗶 No 27. Manner of Death	1 Inpatient 28a. Date of injury	2 ER/Outpatient		4 L Nursing Hor		nce 6 Other (Special	(y)			
0 0	ath. :: After e fune	cate	1 Natural 5 Pending 2 Accident Investiga	(Month, Day, Yea	injury	28c. Injury a work? M 1 🗆 Ye	es 2 🗆 No	8d. Describe ho	w injury occurred				
Division	al or Atter s after des l Director d in by th	Certificate:	3 Suicide 6 Could no 4 Homicide determin	t be	At home, farm, stree ecify)			Ref. Location (Str City or Town	reet and Number or Rura , State)	al Route Number,			
)	e Hospita 124 hours e Funeral iletely fille	Medical	Check Z I Medical Exa	hysician: To the best of my k miner: On the basis of examir urse Practitioner: To the bes	lation and/or investig	ation in my opinion	death occurred at t	he time date and	d place, and dup to the co	upo(a) and manner stated			
/ ;	Vithir vithir comp		29b. Signature and title of certifier	disc Fractitioner. To the pes	t of thy knowledge, di	29c. License r			e cause(s) and manner as 9d. Date signed (Month,				
			) July			RES-	000		une 22	2012			
			30. Name and address of person wh	o completed cause of death		it)							
ı	State Registra	-	31. Date filed (Month, Day, Year)  JUN 29 201	2 32. Registrar's Si	ignature facts	/	···						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20745 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 12:30PM 06 201 Abigal Hand Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Imore Koseda Franklin Mare 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth Social Security Number **Funeral** Year) 2012 (Month, Day, ) Min 38 Months Hours 1 □ M 2 🗓 F Maryland Director June infant Usual Residence of Decedent or items 23a or 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X☐ No Middle River Baltimore MD 10f. Zip Code 10e. Street and Numbe 10g, Citizen of What Country? Funeral USA 21220 13200 Choptank Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. permit. Page 1 and 2 should be flied within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic enterties. 1 X Never Married 2 Married ģ Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angela Hand ပ္ Johnathan Hand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Square Hospital 9000 Franklin Square Drive Rosedale, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 4 ☐ Donation 5 ★ Other (Specify) ⁄in state Signa, e of Euneral S. <sup>22</sup> Name and Address of Facility Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Previable Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate has be 1 ☐ Yes 2 ☐ No 2 WN 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 460 မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No М Investigation 6 Could not be ☐ Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one Ind the of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signato 6-14-12 Res 0000 person who completed cause of death (Item 23a) (Type, Print)

State Registrar Dr. Gwendoline
31. Date filed (Month, Day, Year)

Hand, Babygir

Square Drive, Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month JUNE Elsie Harcum 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OSPI ta HMOVE N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 🗆 M 2 🔀 F Hours Director Yrs 76 VA 231-44-4214 May 18, 1936 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD **Baltimore** Catonsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1505 North Rolling Road 21228 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Yes 2 ื No Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Minister Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **Lewis Fallins** Martha H Fallins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Fallins 18 South Caton Avenue Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ■ Burial 2 □ Cremation 3 □ Removal from State Jul 06, 2012 Baltimore, Md. 4 Donation 5 Other (Specify) Woodlawn Cemetery & Chapel 21. Signature of Fundial Service Lic 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Dav 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural Pending injury 1 Yes 2 No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Box 68760 To the Hospital or Attending Physician: The law requires that the death Records. has certificate Division of Vital this

Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and Title of certifier 29c. License number 007290

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. ATON 900

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Charles Hendricks 8:40 PM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Randallstown Seasons Hospice 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Months Hours Director 1 **K** M 2  $\square$  F Yrs Va 216-48-1398 62 Sep 4, 1949 Usual Residence of Dece permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural" and marked other then "natural" and other traumatic events. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 No **Baltimore Baltimore City** MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A 21216 3200 Westmont Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. δ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 🗌 Widowed 4 📮 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **BGE Employee** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sallie Hendricks <u>Jacob A. Hendricks</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Westmont Avenue, Baltimore, MD 21216 Jacob Hendricks 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jun 28, 2012 Windsor Mill, Md. King Memorial Park 21. Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 2121 Part T. Enter the disease, or complications that/caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Liver Cancer Prrysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): within 24 hours after death.

To the Funerel Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
g Unknown Month Day Year 5 Other (specify) g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tyes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRAJAPANNEMD 6/20/12 DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NSRajapaksemp Baltimore MO 21209 Smith AN SZO3 2835

State Registrar 31. Date filed (MN), 229 Ye 2012

32. Registrar's gnature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#20a, perfff, 6928, 6/29/2012, WS

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 2012 6:00 Bruce Allison AMHansen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1439 Goodwood Avenue **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F Months (Month /13/1946 Color New Jersey 150-38-0538 65 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral be filed within 72 hours after death with 1439 Goodwood Avenue **USA** 21221 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Roofer Construction 8 and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sürname) ၉ Rose Cooney Bruce Hansen other traumatic t. Page 1 and 2 should b tment of Health and Mer rant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1439 Goodwood Avenue, Baltimore, MD 21221 Brenda Barksdale / Daughter 20a. Method of Disposition
1 □ Burial 2 ☐ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date 4 ☐ Donation 5 N Other (Specify) Chesapeake Crematory 6/28/2012 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC Physician, LUNG CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examin cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 physician Physician/Medical the attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? Yes 2 No death? after death.

Director: After this certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 KResidence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending injury Investigation 6 Could not be 2 Accident
3 Suicide
4 Homicide Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) HEMATOLOGIST/ONCOLOGIST 7-51555 06-27-2012 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9103 FRANKLIN SOUAREDRIVE # 2200; BALTIMORE, MD 21237 SEIN AUNG, filed (Month, Day, 32. Registrar Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician/ 1245 AM Willie Haslip 7 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Square FRANKLIN HOSPITCE Baltimore Rosedale g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. If Under 8. Date of Birth **Funeral** 420-36-3636 Months Hours Min Country abama 83 (MODY/P9/19929 Director 1 🗆 M 2 🗆 F 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director MD **Baltimore** 1 Yes 2 No Essex 10e Street and Numbe 10f. Zip Code Ь 10g. Citizen of What Country? must be r Funeral 249 Stemmers Run Road 21221 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian "natural", or ite Black, White, etc. ρ ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Specify Completed Black . II : 3 the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Transportation injury or other traumatic event, Be permit. Page 1 and 2 should be filed.
Department of Health and Mental H-Important: If item 27 is many injury or other 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Oscar Haslip Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phillip Haslip / Father 249 Stemmers Run Road, Essex, MD 21221 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20c. Location - City or Town, State Date 6/29/2012 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Dorota Marshall Maryland Cremation Services, PO Box 1413Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Severe cardio my ocath disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the other function. burial-transi Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No ျှ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 7. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature ∦nd title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

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Registrar

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30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

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JUN 29 2012

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FRANKLIN SQUARE DR Balto md 21237

6-28-2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JUNE 830 PM Physician/ STEPHANIE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death **Ellicott City** 4919 Avoca Avenue Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 215-40-4432 1 □ M 2 🗷 F Months Days Hours 69 th Day, Year) May 2, 1943 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits hours after death with the Maryland 10c. City, Town or Location the Medical Examiner must be notified at Director MD Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 4919 Avoca Avenue items 23a 21043 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stephen John Foriska ည **Eleanor Parker** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lesile Hose Spouse 4919 Avoca Ave. Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Jul 03, 2012 Crest Lawn Memorial Gardens Marriottsville, Maryland 4 Donation 5 Other (Specify gr Fuyeval S. price Line any inj 22. Name Sidck Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 200531 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final Physician a ncrea dise se or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death been signed by the sahould be detached Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à MEllitus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death?

1 Yes 2 No autopsy this certificate has 24 hours after death.

Funeral Director: After this certific leted filled in by the funeral director, Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 2 - No 1 Yes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 Natural 5 Pending 2 🗆 No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one)

State Registrar

31. Date filed (Month, Day, Year)

STEVENS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6350

Registrar's Signature

29c. License number

40036

29d. Date signed (Mouth, Day, Year)

MS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $J_{une}^{Month}$  25, 2012 4:36 Irene Ssu-chin Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 3510 Tarkington Lane Silver Spring 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours June 24, Year 929 China 092-28-2570 83 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the <u>Medical Examiner</u> must he marked once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 3510 Tarkington Lane United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Asian 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Artist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Lucile Wang J. Heng Liu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Hou 115 Chisman Circle, Seaford, Virginia 23696 20a. Method of Disposition
1 ☐ Burial 2 ဳ Cremation 3 ☐ Removal from State e 30, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Montgomery Crematorium, Inc. June 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 2012 M01305 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Signature of Funeral Service Licensee physlite Brytiel 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myeloproliferative Disorder Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death signed by the at the detached for 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anemia, Hypertension, Myocardial Infarction 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform is certificate has director, page 2 death?
1 Yes 2 No performed? 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) After thi 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d, Describe how injury occurred 1 X Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

only one 29b. Signature

31. Date filed (Month, Day, Year,

9715 Medical Center Drive, Ste. 221, Rockville, Maryland 20850 Joseph Kaplan, M.D. JUN 29 2012 ack

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D35635

29d. Date signed (Month, Day, Year) June 25, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2012 1:35 Mildred Jeanette Harp 26 AM June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) 370-16-4128 Director 1 M 2 X F 90 April 12, 1922 Michigan 10b Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 3503 S. Leisure World, Blvd. #2A United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. <u>ک</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give White Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Federal Government æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hobart McKinley Crouch Genevieve Thral1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3618 Gleneagles Drive, #3G, Silver Spring, MD 20906 Phillip B. Sheets Date 29 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 D Cremation 3 Removal from State June 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signature of Fun and Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Hospitel or Attending Physicien: The lew requires thet the deeth certificete be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 use es the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy þ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 8 Coronary Artery Disease 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen Pneumonia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 🗌 Yes 2 🗎 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner/ 1 ☐ Yes 2 🔀 No Hospital: Other: 4 Nursing Home 5 Residence 6 K Other (Specify) မ Hospice 1 Inpatient 2 ER/Outpatient 3 DOA t) 24 hours after death.
Funerel Director: After thi etely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Detrifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signarure and title of certifier 29c. License number R143201 6.26.12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Debrah Miller, CRNP

29 2012

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

32. Registrar's Signature

6001 Muncaster Mill Road, Rockville, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State (	of Maryland / Depa	artment of Heartificate of De		Hygiene Reg. No.	2012	20753
35	Physicia		1. Decedent's Name (First, Middle, Last)  Mafa	lda M. Houtz		2. Date Month	Day	012	3. Time of Death 4:30 A M
	/Medic Examin		a. Facility Name (If not institution, give street and not Potomac Valley Nursing		4b. City, Town, or Loc Rockvi			County of Death	
	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 🖾 F	7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year   If	Under 24 Hrs. 8. Date	h, Day, Year)	Cor	place (State or Foreign intry) ISY1vania
15	D		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary Ifed	tor	Maryland Montgomery	Gai	thersburg			!	1 ☐ Yes 2 X No
	or 282	Director	10e. Street and Number		10f. Zip Code			zen of What Cou	•
	a 23a	era	17015 Sioux Lane	cedent Ever in U.S. 13.	20878 Was Decedent of Hispa	anic Origin? (Specify Yes		ed Stat	
920	urs after de el', or Item Exeminer	by Funeral	Amed F	orces? 2 🔼 No live	If Yes, specify Cuban, N	Mexican, Puerto Rican, et Specify:	:.)	Black, White Specify:	White
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptyglene. Important: If Item 27 is marked other then "naturel", or Itema 23a or 28a-f show ship injury or other traumatic event, the Medical Examinar must be notified at ance.	Completed by	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0·12)  College	(Give (1-4or 5+)	dent's Usual Occupation  kind of work done durin  DO NOT use retired)  omemaker	n ng most of working		nd of Business/I	ndustry
d 2	al Hygin other	Be Co	17. Father's Name (First, Middle, Last)		18	B. Mother's Name (First, N		Sumame)	
ylaı	ould b Ments	To	Salvatore Intorre	105 145	Add /G	Adaline Number or Rural Route I		Town State 7	in Codel
Maryland	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship (Type, Print) Raymond E. Houtz/Husban	11.		e, Gaithersb			
Baltimore,	Pages 1 and the point of Heem int: If item		20a. Method of Disposition  1   □ Buriai 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	n State	osition (Name of matory or other place)  Cemetery	July 2, 20	12 Stat	cation City or e Colle ennsylv	ege.
Balti	permit. Departm Imports sny inju		21. Signature of Funeral Service Licensee	MUU198 75	557 Wisconsi	of Facility mphrey Funer; n Ave., Beth	esda, M	Betheso Chase aryland	la-Chevy 20814-3501
	Physician		23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause or immediate Cause (Final	caused the death. Do not en	iter the mode of dying, s	such as cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
/教室	/Medical Examiner		disease or condition resulting in death)  a  Due t	o (or as a consequence of):	VII COC				gen -
*	bed 's	Examiner	cause. Enter Underlying Cause (Disease or injury	o (or as a consequence of):					
8760,	certificate be executed iding physician and ise as the burial-transit	ai Exar	that initiated events c.	o (or as a consequence of):					
Box 687	leath certificate attending phy. I for use as the	Physician/Medicai	23b. Was decedent pregnant		□Ectopic pregnancy	-		23d. Date of del	ivery Day Year
P.O. E	the dea by the at ached fo	nysici	1   Yes 2   No 9   Unknown		Other (specify)				
	equires that the de sen signed by the a rould be detached	þ	Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given	in Part I. 23e		use contribute to XNo 3 ☐ Pr	the cause of death?
Records,	e taw r has be je 2 sh	Completed					Was an autopsy performed?,	prior to death?	stopsy findings available completion of cause of
Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		Other	6. Place of Death (Check			
of	Phys this aldi	. To		☐ Inpatient 2 ☐ ER/Outpatie te of Injury 28b. Time onth, Day Year) Injury		4 Vursing Home 5 L	Residence cribe how inju		city)
ion	tending I feath. tor: After the funer	ation	2 Accident investigation	o <i>nth, Day Year)</i> Injury		s 2 No			
Division	after de after de Directo	Certification:	3 Suicide 6 Could not be determined 28e. Pla	ce of Injury - At home, farm, s Iding, etc. <i>(Specify)</i>	street, factory, office		ation (Street ar or Town, State		ural Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	ledicai C	29a. Certifier (Check only one)	the best of my knowledge, dea basis of examination and/or anner stated.	ath occurred at the time, investigation, in my opin	, date and place, and due tion, death occurred at the	to the cause(s time, date an	) and manner as d place, and due	s stated. a to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	0	29c. License n			ite signed (Mont	h
			mende	ugll 1	10 D30	5262	1 20	me 2	7,2012
			30. Name and address of person who completed completed to the second of	177A 901	43 Sha	3262 dyGove	Conr	moga.	thersburg 20877
	St Regist	ate trar	31. Date filed (Month, Day, Year)	Registrar's Signature	Ker				

DHMH 17 Rev 1/2001

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		For State		State of f	viai yiaiiu / i		ate of L		and ivic	-	Reg. No.	201	2 2075
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Physicia Medic			C	onstance	M. Jame	S				Month Ju M=	2 2	Year 2012	15 36 4 14
Examir			. •	ve street and number	*		City, Town, or					County of Deat	
Funeral Director		5. Social Security Nu 214-44-00	mber 6.		Age (In yrs. last birt	hday) If U Mor Yrs.	nder 1 Year ths Days	If Under 2 Hours	24 Hrs. 8 Min.	Date of Bir. (Month, Da <b>May 7</b>		9. Bir Co	thplace (State or Foreign untry) MD
T on		Usual Residence o	f Decedent 10b, County		10c. City, Town								10d. Inside City Limits
Marylan 28a-f sh otiffed a	Funeral Director	MD	Balt	imore	Toc. Gity, Towl		F	Randalls	town				1 🗆 Yes 2 🗀 No
with the s 23a or ust be n	eral D	10e. Street and Num 5105 Old Co				10	f. Zip Code	2113	3		10g. Citiz	en of What Co U.S.	
15-0036 72 hours after death with the Maryland n "natural", or items 23a or 28a-f show ledical Examiner must be notified at		11. Marital Status  1 Never Marri 3 Widowed		12. Was Deceder Armed Force 1 ☐ Yes 2 If Yes, Give Year or Dates	? ☐ No		ecedent of H specify Cuba es 2 No		in? (Specify , Puerto Ric	y Yes or No- an, etc.)	- 1	4. Race - Ame Black, White pecify: <b>Bla</b>	e, etc.
5-0 hours	lete	Gnov	15. Decedent's				Usual Occup		of working		16b. Kin	d of Business	/Industry
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re, Maryland 21215-0036  1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. item 27 is marked other than "natural", o other traumatic event, the Medical Exam	To Be	17. Father's Name (F		Harrison B. J	lames			18. Mothe	r's Name <i>(F</i>	First, Middle,	Maiden St arie Ja		
Mary 12 should with and M 27 is ma		19a. Informant's Na Charles Ja		(Type, Print)	195	. Mailing Add	dress (Street a	and Number Road Ba	r or Rural R altimore	oute Numbe , MD 21	r, City or To <b>230</b>	own, State, Zij	o Code)
Baltimore, permit, Page 1 and Department of Heamportant: If item any injury or othe once.				☐ Removal from Sta		f Disposition ry, crematory t. Zion Co	or other place	ce)	Dat <b>Jun 26</b> ,			ation - City or	Town, State e, Maryland
Baltimo permit, Page Department of Important: If any injury or		21. Signatur of Pur		1	10	22. Nam	e and Addre Estep Bro 1300 Euta	ss of Facility others Fu aw Place	ineral Se Baltimo	ervice, P. re, Md 21	A. 1217		
Physician/		shock, or hear Immediate Cause (I disease or condition	t failure. List only Final	mplications that cau one cause on each	eed the death. Do rine.  TASTATIC as a consequence of the consequence	not enter the	mode of dyin	g, such as c	cardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death
Medical Examiner		resulting in death)	•	Due to (or a	as a consequence	of):	TASIC						WICHOWN
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ords, P.O. Box 68760 requires that the death certificate be been signed by the attending physici should be detached for use as the bu	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☑ 9 ☐ Unknown	nonths?		h 2 ☐ Fetal deatl t at time of death		opic pregnancer (specify)	Sy			2	3d. Date of de Month	livery Day Year
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of V g Phys er this	E.	27. Manner of Death		28a. Date of in	njury 28b.	Time of njury	28c. Injur	y at		d. Describe l			ny)
ision of Vital Attending Physician: r death, sector: After this certific	Certificate:	1 Natural 2 Accident 3 Suicide	5 ☐ Pending Investigati 6 ☐ Could not	on		M		Yes 2 🗌	No				
Division all or Attendines after death.		4 Homicide	determine	28e. Place of I	Injury - At hóme, fa etc. <i>(Specify)</i>	ırm, street, fa	ctory, office		28	f. Location (S City or Tov		Number or Ru	ral Route Number,
Division of To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	(Check 2	Medical Exa	nysician: To the best miner: On the basis o urse Practitioner: To	f examination and/o	or investigation	n, in my opini	on, death oc	curred at the	e time, date a	and place, a	and due to the	cause(s) and manner state
To the Comp	-	29b. Signature and					29c. Licens	e number			29d. Date	signed (Mont	h, Day, Year)
		1		ATT	ENDING		700	5694	· V		JUN	JE 2	5 2012
3		30. Name and addre	TANSIN	completed cause o	f death (Item 23a)	Type, Print)	VE #	204,	BALT	moné	n	212	29

State Registrar

31. Date filed (Month, Day, Year)

JUN 29 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June June 2012 1:15 PM Farhad Sevd Javid Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rockville Montgomery Casey House 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral Social Security Number Hours Months Min (Month, Day, Year) Country) Director 578-64-2780 1 X M 2 D F 1945 Nov 22, Iran 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20872 24623 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. 1 Never Mamied 2 Married ģ 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Secondary (0-12) College (1-4 or 5+) Information Technology Computer Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tourandoht Satari Mohammed Javid-Kermani 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4140 N. Central Ave. #3033 Phoenix, AZ 85012 Talia Dardis / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey Crematory 06/28/12 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service Licens Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Colon Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the attending ph IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death signed by the a g Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2X No 3 ☐ Probably 4 ☐ Unknown 1 Yes certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 X No 1 Yes 2 No director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 XOther (Specify) 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this Director After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending death. 2 Accident
3 Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined ناه 24 hou the Funeral Dire hours after Hospital Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2
To the I
complet only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6.26.12 R143201 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller 6001 Muncaster Mill Rd. Rockville, MD 20855

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

29

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#26perPHYS, G928, 6/29/2012, WS
State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar					Certifica	ate of L	Death			Reg. No.	201	2 20	756
	Physicia	n/	1. Decedent's Name (Fin			2. Date of De Month U6	ath 28	2012	3. Time of							
and the state of t	Medic	al				s E. Jacks	on	1				06				Ам
	Examin	er	4a. Facility Name (if not 12218 Westn	, 0	street and num	ber)		4b. Ci	ty, Town, or	Bow			4c.	County of Dea Prince	th George's	
	Funeral		5. Social Security Numb	er 6. S	ех	7. Age (In yrs. 91	last birthd Yr	Month	der 1 Year is Days	If Under Hours		8. Date of Bir (Month, Da		g. Bi	thplace (State o	r Foreign
	Director		Usual Residence of Dec			71	11.	·.				12/10	/1920		iviai y iaiid	
	and show lat	jo.		b. County		10c. Ci	ty, Town o	r Location							10d. Inside Cit	,
	Manylk '8a-f	rect	MD	Prince C	George's					Hyatts	vile				Y Yes	2 🗆 No
	the l	Ö	10e. Street and Number			•		10f.	Zip Code				10g. Citi	izen of What C	ountry?	
	h with	Funeral Director	8812 Sterli	ng Street						2078				US	Α	
	r iten	/Fu	11. Marital Status	• 🗆 • • •	Armed For		S.	<ol><li>Was Dec</li><li>If Yes, sp</li></ol>	cedent of Hi becify Cuba	ispanic Ori in, Mexicar	gin? (Spe ı, Puerto	ecify Yes or No- Rican, etc.)		<ol> <li>Race - Ame Black, White</li> </ol>		
21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	ted by	1 ☐ Never Married 3X☐ Widowed 4 ☐		1 ☐ Yes If Yes, Give Year or Da	е		1 🗌 Yes	X No	Specify:				Specify:	Black	
15-	72 hol	ple		5. Decedent's E only highest gra	ducation ade completed)		1 (0	ecedent's Usive kind of v	vork done c	ation during mos	t of work	ing	16b. Ki	nd of Business	Industry	
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<b>d</b> 2	led within Hygiene. other thar ent, the M	Be	17. Father's Name (First,	, Middle, Last)							er's Nam	e (First, Middle,	Maiden S			
Maryland	should be file n and Mental h 7 is marked o raumatic eve	욘			Allen Ha	ıll							France	es		
ary	hould and N is ma		19a. Informant's Name/	Relationship (T	ype, Print)		19b. N	lailing Addre	ess (Street a	and Numbe	er or Rura	al Route Numbe	er, City or	Town, State, Z	ip Code)	
	and 2 s Health (em 27 i		Gwendolyn L.	. Riley / D	aughter			8812	2 Sterlin	g Stree	t, Hya	ttsvile, M	D 207	85		
ore	e 1 ar i of H		20a. Method of Disposit		Removal from		Place of D cemetery,	isposition (N crematory o	lame of or other plac	:e)	1	Date	20c. Lo	ocation - City o	r Town, State	
Baltimore,	t. Page tment o rtant; If ijury or		4 ☐ Donation 5 ☐	Other (Special	fy)		Chesap	eake Cr		-		/2012		Beltsvil	le, MD	
Ba	permit. Page 1 and Department of Hea Important; If item any injury or other once,		21. Signature of Funeral Dorota Marsha		he Who	ushall			and Address land Cre		•	ices, PO E	3ox 14	13 Baltim	ore, MD 21	1203
			23a. Part 1. Enter the d shock, or heart fai	lisease, or com	plications that c	aused the dea	th. Do not	enter the m	ode of dyin	g, such as	cardiac o	or respiratory ar	rest,		Approximat Interval Bet	e ween
2	Physician/	8 8	Immediate Cause (Fina disease or condition	ıl	. 56	28T1	_	5 130	ocv	<					Onset and I	Death
-	Medical Examiner		resulting in death)		Due to (	or as a conseq	uence of):				_					
		er	Sequentially list conditi	ions,	b. 0.2	1 N A		10	-AC	1	16	ECTI	ンマー		0440	
8	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or iinju	g Iry				12021	c \	JAC	206	-A2 D	150	456	YEAR	-<
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Box (	ath ce attenc for us	cian	23b. Was decedent pred in the past 12 mon	ths?		Birth 2  Fet	al death	3  Ectop 5  Other		су			10	23d. Date of de Month		Year
Ω.	he de	Physician	1 Ves 2 No 9 Unknown	0	9 Unkr		a cuti	0 2 0 1110	(0,000,00)							
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ta	cian; ertific ector,	Be	25. Was case referred to examiner?	- 1	Hospital:					ace of Dea					daught	ter's
fΝ	Physi this c al dire	2	1 Yes 2 No.	0	1 28a. Date	Inpatient 2	ER/Outp		DOA Othe	4 N	ursing Ho	ome 52 Resi 28d. Describe I	dence 6	Other (Spe	daugh reside	ence
n o	ding th. After funer	cate		Pending Investigation	(Mon	th, Day, Year)	inju		work		.	260. Describe	now injury	occurred		
Division of Vital Records,	Attender dea ector:	Certificate:		Could not be determined	e 28e. Place	of Injury - At h			cory, office					d Number or Ru	ıral Route Numb	er,
Ω̈́	urs after ral Dir				1	ng, etc. (Specif						City or To				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 🔲	Medical Exam	sician: To the b iner: On the bas se Practioner:	is of examination	on and/or it	vestigation,	in my opinie	on, death o	ocurred a	t the time, date :	and place,	and due to the	cause(s) and ma	nner stated.
	Vithi To th	_	29b. Signature and title	of certifier			-	2	29c. Licens	e number	0		29d. Dat	e signed (Mon	h, Day, Year)	
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	Sta	te	JUN 29 2	UIZ /2	- seens	egistrar's Sign	2 Ken	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 01:30 PM Grace Diane Johnson June 2012 2 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Abingdon 2513 Laurel Valley Garth Harford If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number . Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 218-60-4726 **Director** 1 □ M 2 🛛 F Yrs. 59 Usual Residence of Decedent Maryland 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland must be notified at Director 1 🗌 Yes 2 🔀 No Maryland Harford Abingdon 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 9 Funeral items 23a USA 21009 2513 Laurel Valley Garth 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. the Medical Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. "natural", Completed 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant U.S. Government Be or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ပ Flossie Elaine Brown permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. Theodore Roosevelt Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keisha D. Johnson / Daughter 2513 Laurel Valley Garth, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Harford Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 6-28-12 Aberdeen, Maryland 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Road, 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ck, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final dise e or condition resulting in death) Onset and Death Physician/ au ce-Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to forms a consequence off Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 24 hours after death.

• Funeral Director: After this certificate has been signe etely filled in by the funeral director, page 2 should be. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 Tes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5. Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes Accident Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 P.O. Division of Vital Records,

Registrar

Medical

31. Date filed (Month, Day, JUN 29 2012

29a. Certifier

only one)

29b. Signature and title of certifier

a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 2

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ETY Aviation Klud

		_	roi	State of Marylan				Mental Hy	giene	010	00750
		_	State Registrar		Cer	tificate of E	Death	_	Reg. No.	U12	20108
	Physicia Medio		1. Decedent's Name (First, Middle, Last)  Catherine M. Joh	nson				2. Date of De		<u> </u>	3. Time of Death
0	Examin		4a. Facility Name (if not institution, give stree Saint Joseph M		nter	4b. City, Town, or	Location of Deat	h		ty of Death	ore
1	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. Is		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th	_	lace (State or Foreign
	Director		Usual Residence of Decedent		37 Yrs.			05/09/	1925	Mary	
	aryland a-f sho filed at	Director	MD 10b. County Baltimor		y, Town or Loc	ation Tows	on			11	0d. Inside City Limits  1 Yes 2 No
	a or 28 be noti	al Dir	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Coun	try?
	th with ms 23 must	Funeral	604 Lake Avenue	N. D	- I40 V	2128		if . V-o - No	U.S.		
17L	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates,		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No		pecify res or No- to Rican, etc.)		ace - America ack, White, $\epsilon$	etc.
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14heur 21215-0036	vithin 72 iene. ir than the Me			College (1-4 or 5+)	life. DC	NOT use retired) tal Tec		9	G	ВМС	
	e filed v ttal Hyg ed othe event,	To Be	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maiden Surnai	ne)	
7 Service	should by and Mer is marke aumatic		Thomas Lawrence  19a. Informant's Name/Relationship (Type, I	Print)	19h Mailin	g Address (Street a		Smith	er City or Town	State, Zio C	Code)
ZZ,	id 2 sh salth ar n 27 is er trau		Freddie M. Lawre			-					MD 21215
otheson more, Mary	Page 1 and ment of Heal ant: If item; ury or other		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	emetery, crem	sition (Name of natory or other place Cremat		Date A K	20c. Location	•	
Johnson, C Baltimore, Maryland	permit, P. Departme Importar any injur		21. Six tur of Funeral Service Libenser	, ,	29	OSEPH <sup>dd</sup> H	* Brown	Jr. Fu	neral	Home	PA
	20200		23a Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca	ions that caused the death						nore,	MD 21217 Approximate
	Physician/	35 Y	Introduct Cause (Final ease or condition resulting in death)	Right Ven	tricul	ar Fa	ilure			5	Interval Between Opeet and Death
	Medical Examiner	IJ	<b>1</b> 3	Rimonar	11	perten	sion			5	i-10 years
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of the consequence of t	uence of):	arcoido					
	ate be executed physician and the burial-transit	al Exa	that initiated events c resulting in death) Last	Due to (or as a consequ		<u> </u>	<u> </u>				
760	cate be physic s the bi	ledical	d								
x 687	eath certifica attending p	Physician/Me		If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta	aldeath 3		ey			Date of delive	ery Day Year
Box	the dear	hysic		4  Pregnant at time of c	death 5 L	Other (specify)				Юпит	Day Tour
s, P.O.	the Hospital or Attending Physician: The law requires that the death certificate be executed from the Ad hours of the death. The Hospital Director: After this certificate has been signed by the attending physician and the therethy filled in by the funeral director, page 2 should be detached for use as the burial-transity than the funeral director, page 2 should be detached for use as the burial-transity.		Part II. Other significant conditions contrib	outing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did t	- 4		e cause of death?
ord	tw requires as been sig 2 should I	Completed by						24a. Was auto		. Were autop	osy findings available mpletion of cause of
Rec	'sician: The law a certificate has k director, page 2 s		25. Was case referred to medical				15 4 (0)	perfo 1 ☐ Yes	ormed?	death? 1 Yes	2 No
Vita	ysician: Tasician: I	To Be	examiner?	oital:	ER/Outpatien	Othe	ace of Death (Che	Home 5 Resi	dence 6 🗆 O	her (Specify)	)
n of	d <b>ing Ph</b> y h. After this funeral		1 X Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	/ at	28d. Describe			
Division of Vital Records,	I or Attendi after death, Director: A d in by the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre		res Z 🗆 No	28f. Location ( City or Tov		ber or Rural	Route Number,
ام	Hospital o 24 hours af Funeral D stely filled i		29a, Certifier 1 Certifying Physician	n: To the best of my know	ledge, death o	occurred at the time	e, date and place,	and due to the c	ause(s) and ma	nner as state	ed.
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check 2 ☐ Medical Examiner: only one) 3 ☐ Certifying Nurse Pr	On the basis of examination	n and/or invest	igation, in my opinio death occurred at t	on, death occurred he time, date and	at the time, date a	and place, and o the cause(s) and	lue to the cau I manner as s	use(s) and manner stated. stated.
	viit oo		29b. Signature apertitle of certifier	M.O.		D 6	number 5045	-	29d. Date sign	ed (Month, I	Day, Year)
1)			30. Name and address of person who comp	leted cause of death (Item	1 23a) (Type, P			C+. LL	19 77/11	ISOA)	MY SISON
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signar		305 US	TU U	Suit 40	1 100	, 3010	114 21409
. /	Registra	ar	HIN 2.9 2012 /2-		racke						

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OG Year Physician/ MAY Jones 331 AM KAY 24 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Harter Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral Director** 212-40-0814 1 □ M 2🛣 F 71 06/10/1941 PAUsual Residence of Dece 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director Darlington 1 Yes 2 No MD Harford 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Examiner must 21034 USA 1630 Whiteford Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. l Hygiene. other than "natural", or i Completed by 2 XNo 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) the Property Management Administrator remit. Page 1 and 2 should be filed w
Lepartment of Health and Mental Hygi
Interact. If item 27 is marked other
any injury or other traumatic event, it Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Sadie Arlene Montz Charles Minnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1630 Whiteford Rd., Darlington, Md 21034 Westley R. Jones, Sr - Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/27/2012 Weatherly, PA Union Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Schimunek Funeral Home teral 610 W. MacPhail Rd., Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Hypertensive Attendentie Cardiovascular Disease 000 6/24112 Medical to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to innihilate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of it and I-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Dav Year 1 Yes 2 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Hipertensien 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform sones, I 2 No Yes 2 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 K Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital or To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie D0069723 30 gm Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 upperchosapeake Drive Bel Air MD 2101U

Registrar DHMH 17 Rev 06-2011

State

Hornyak

31. Date filed (Month, Day, Year)

JUN 29 2012

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Raymond Leo Johenning, Jr. 23:34 M 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air . Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year, Director 218-48-0474 1 XM 2 F 04/20/1948 ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Bel Air Harford 10e. Street and Number 10f. Zîp Code 10g. Citizen of What Country? Funeral USA 21014 951 Redfield Road, Apt. J 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. ð 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Distribution Company Risk Manager and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emma Mary Reimsnider Raymond Leo Johenning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. 445 Moores Mill Rd., Apt 1, Bel Air, MD 21014 Laura C. Johenning - Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 Cremation 3 Removal from State 125/13 07/02/12 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 610 W. MacPhail Rd., Bel Air, MD 21014 lart . Enterthe distase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shoot, or he intigations. List only one cause on each line. Interval Between
Onset and Death Immediate Cause F al Physician/ disease or condition resulting in death) ung cancer Medical Due to (or as a see sence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transi enring, Baymond that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: detached for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Dav Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 **X** No Other: 1 Tes မ 1 Expatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ot 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled n by determined To the Hospital within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 29b. Signature and title of certifier DO053568 June 26, 2012 Air Maruland ZIOH e and address of person who completed cause of death (Item 23a) (Type, Print) 1 hongson MD Mary land 31. Date fied ( + ay, Year)

DHMH 17 Rev 06-2011

State Registrar

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32. R istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Louise Μ. Jackson 06 2012 11:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville Morningside House Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days 99 **Director** 218 07 6495 1 □ M 2 🗓 F 01/10/1913 MD or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Parkville Baltimore 1 ☐ Yes 2X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 U.S.A 8800 Old Harford Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White If Yes, Give Year or Dates 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ye 1 and 2 should be filed within 7. t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Retail 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Flora Schmidt John Schlee other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5517 Daywalt Ave. Baltimore, Md 21206 Anita Barrett (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 06/30/2012 4 ☐ Donation 5 ☐ Other (Specify) Moreland Cemetery Baltimore, Md Signature of Faneral Sex ce Licens 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd Nottingham, Md 21236 . Enter the disease, or complications that caused, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ementia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attending d be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cancer 2 No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? mellitus 24a. Was an autopsy this certificate has 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Prwithin 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide work? 1 \sum Yes 2 \sum No injury 5 Pendina Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License number

State

Registrar IIIN 2.9

30. Name and address of per

vid

31. Date filed (Month, Day, Year)

Naman, us 5601 Loch Raven Blod., Baltimore, Us

Benefit Signature

B. Santa S. Santa

on who completed cause of death (Item 23a) (Type, Print)

D0052583

June 26,2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month OVO ing 01 un Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** lizabett timou ent Wysing Social Security Number ge (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Hours Min. De Cont 24 ay 1923 Pennsylvania Director 213-20-2066 88 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 USA 4527 Ridge Drive within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, et Š 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes Give 3xxWidowed 4 ☐ Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 0 Home Maker t. Page 1 and 2 should be filed witt tment of Health and Mehtal Hygien rtant: If item 27 is marked other i jury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Emma Weaver David G. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Gould / Daughter 8611 Imagination Ct., Walkersville, Maryland 21793 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Loudon Park Cemetery June 30, 2012 Baltimore, MD 21. Signature of the neral Se 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on euch line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a son a quence of) cause. Enter Underlying Cause (Disease or linjury Exam or Attending Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last s been signed by the attending physician should be detached for use. Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No disorder uve 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed? evillidemi has page 2 After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 🗌 Yes |2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 1 Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation within 24 hours after deat To the Funeral Director: completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Avenue Û State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June June 28 2012 4:25 Αм Carol S. Kerr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Rockville Casey House If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Days Hours (Month, Day, Year) Director 213-54-6492 1 M 2 K F June 8, 60 1952 Maryland show 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20906 United States Leisure World Blvd #120 3100 N. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Specify: White Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Department of Elementary/Secondary (0-12) College (1-4 or 5+) Transportation Transit Planner Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or com 18. Mother's Name (First, Middle, Maiden Surname) မ (unk) Evelyn Milton Eisen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 3100 N. Leisure World Blvd #120 Silver Spring, MD Robert Kerr / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 6/29/2012 Woodbine, Maryland 21. Signature of Funeral Service Lices Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 wu 110 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease of injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 X Natural 5 Pending injury 24 hours after death. e Funeral Lirector: Aft eletely filled in by the fur 2 Accident Investigation 6 ☐ Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical 29a. Certifie 1 🛄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🔀 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 6.28.12 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Debrah Miller

31. Date filed (Month

Registrar's Signature

6001 Muncaster Mill Rd. Rockville, MD 20855

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James Ε. King 08464M 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death of Ba Himore Balti more Hospital 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Hours Month, Day, Yea 70 226-54-6327 1**X** M 2 □ F **Director** 1941 Virginia Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland notified at Director 28a-f MD N/A Baltimore 1 X Yes 2 No 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I Funeral with 1 21209 3017 Apt. E., Romaric Ct. USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify If Yes Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Painter Ship Yard Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Harris James Β. Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tractone. Sally A. Martuscelli (Per. Rep.) 3017 Apt. E., Romaric Ct., Baltimore, MD 21209 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory 6/26/12 Baltimore,Maryland 4 Donation 5 Other (Specify) loudon Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part F. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Inset and Death Physician Om.nJ disease or condition ardiac Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death been signed by the s should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After this certificate I 2 6 No 1 Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 400 ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cent 29c. License number 29d, Date signed (Month, Day, Year) av 0021730 2012 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) Bultimore at lari

DHMH 17 Rev 06-2011

State Registrar 2. Registrar's Sign

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 M Medical active hame (if not institution, give street and number) Town, or Location of Death. **Examiner** 4c. County of Death 8. Date of Birth (Month, Day, Year)
Dec. 5, 1949 9. Birthplace (State or Foreign Country) Rhode Island **Funeral** Social Security Number 7. Age (In vrs Year If Under Hours 217-56-4814 Director 1 XM 2 | F 62 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2X No MD <u>Baltimore</u> <u>Catonsville</u> 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 2 Six Notches Court 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【※No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 Married 21215-0036 White 1 Yes 2 No Specify: and Mental Hygiene.

// is marked other than "natural", marked other than "natural", marked event, the Medical Exa If Yes, Give 3 - Widowed 4 M Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Agent Insurance Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roger C. Kuhn, Sr. Mary Alice Licthenwalner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. Dianna Christie-Executrix 302 Estate Road; Reisterstown, MD 21136 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory Glen Burnie, MD 6/29/2012 4 Donation 5 Other (Specify) Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service License uneral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsvill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Month Year Day Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by d be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes plnous 24b. Were autopsy findings available 24a. Was an page 2 prior to completion of cause of death? performed? Yes 2 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 No 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending s after death. I Director: Af 1 Yes 2 No Accident the Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29b. Signatur pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day 32. Registrar's Signatur State 9

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #778 per FH G928 6/29/2012 Jn
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Year Physician/ JUNE PAUL KLEBANOW 26 05:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GILCHRIST HOSPICE CARE TOWSON BALTIMORE 8. Date of Birth (Month, Day, 1926) 05/26/1927 Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, **Funeral** Min. Days Hours 215-22-4496 86 85 Director 1 XM 2 F MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene and "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE OWINGS MILLS 1 Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3410 ASSOCIATED WAY, APT. 221 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11 Marital Status Armed Forces?
1 

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. WHITE Specify: 3X Widowed 4 ☐ Divorced If Yes, Give Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 CONTRACTOR HOME\_IMPROVEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 UNKNOWN KLEBANOW SCHWEITZER TILLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAYMOND KLEBANOW / SON 3934 BRITTANY LANE HAMPSTEAD, MD 21074 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, MARYLAND VETERANS CEM: 7/02/2012 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Prysician/ Renau wells ForLue disease or condition Medical resulting in death) **Examiner** ASDO MY OLY SI weeks Sequentially list conditions, ence of if any, leading to immedic cause. Enter Underlying Weeks Exami Cause (Disease or injury that initiated events and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ ρ in the past 12 months? Month Pregnant at time of death Yes 2 No 4 ☐ Pregnant 9 ☐ Unknown be detached 1 L Yes 2 L 9 L Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KIDNEY distake, Rend Coll Carcinoma 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an on king distance certificate has autopsy 2 🗌 No Yes 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nespile 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at After ' ☐ Natural 5 Pending FALL 24 hours after death. Funeral Director: Af INC 7 2012 1 ☐ Yes 2 ☑ No 2 Accident M Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) City or Town, State) OWING MICLS, 3410 AssociARD hanc Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 29b. Signature and title of certifie M

DHMH 17 Rev 06-2011

State

Registrar

30. Name and

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dd ess of person who completed cause of death (Item 23a) (Type, Print)

AMUES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mine 2012 PIERCE JOHN 9:40 PM KENNY Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death N owson timore a . Age (In yrs. last birthday) Year If Under 24 Hrs. If Under 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Days Director 096-34-9339 1 💢 M 2 🗆 F 68 11/28/1943 NEW YORK or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE TIMONIUM 1 Yes 2 X No ò 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a or Examiner must be by Funeral 2300 DULANEY VALLEY ROAD 21093 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes Give Completed 3 Widowed 4 Divorced Specify: WHITE event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ PRIEST CATHOLIC CHURCH Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHN F. KENNY EUGENIE PIERCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 Health a tem 27 i REV. GERARD SZYMKOWIAK, C.SS.R. 2300 DULANEY VALLEY RD., TIMONIUM, MD permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 6/29/12 STATON ISLAND, NY ervice Licensee LTLLY Address ZETLER INC. FUNERAL HOME 700 S. CONKLING ST., BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. na disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Ecquerniany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the I IF FEMALE ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown the Hospital or Attending Physician: The law requires that the death thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the atter ó Pregnant 5 Other (specify) Pregnant at time of death Month Day detached ate has been signed by page 2 should be detac Part IJ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 X No Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 State 2. Registrar's Sigr Registrar

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

George Kenton	1- For State	te of Maryland /	Department o Certificate o		d Mental H		teg. No. 2 (	012 207
Physician/ Medical Examine	Registrar  1. Decedent's Name (First, Middle, GEORGE	Last)	KEN	TON	· · · · · · · · · · · · · · · · · · ·	2. Date of Dea Month June 21,	ath	3. Time of Death 1728 hrs
Funeral	4a. Facility Name (if not institution, 18609 Chickadee Lane     5. Social Security Number		(In yrs. last birthday)	4b. City, Town, or I Gaithersburg	g If Under 24Hrs	s. 8. Date of Bi		
Director	217-21-3601  Usual Residence of Decedent  10a. State 10b. County	X  M 2 F	35 Yrs		Hours Mir	08/31	/1976	ComPARYLAND  10d. Inside City Limits
the Maryland a or 28a-f show any tified at once. Director	MD MONTH	GOMERY		ERSBURG	,	<u> </u>	log. Citizen of What	1 Yes 2 XXNo
fler death with the Maryland 1", or items 23a or 28s-f sho ter must be notified at once. y Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent E		20 as Decedent of Hisp es, specify Cuban, Yes 2 X No	, Mexican, Puerto		White,	American Indian, Black,
5-0036 led within 72 hours afth frygene. other than "natural" the Medical Examing Completed by	15. Decedent's Education (Specif Elementary/Secondary (0-12)  N/A  17. Father's Name (First, Middle, L.	y only highest grade comp College (1-4 or 5	+) during m	nt's Usual Occupations of working life.  DISABLE	DO NOT use ret	ired)	16b. Kind of Busin N / N	
21215-0036 hould be filed within 7 in Mental Hygiene. is marked other than interest, the Medical To Be Comple	GEORGE SYI  19a. Informant's Name/Relationship	VESTER (Type, Print )	- 17	g Address (Street	LIND tand Number or	A LO	NG mber, City or Town,	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Impurtant: If item 27 is marked other than "natural", or items 23a or 28a-f she injury an other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	LINDA LONG / N  20a. Method of Disposition  1 Burial 2 XCremation  4 Donation 5 Othe Spec  21. Signature Force Scrice Li	3 Removal from State	20b. Place of Dispos crematory or ot BAYVIEW	sition (Name of cent her place) CREMAT	ORY 6/	Date 23/12	20c. Location - C	D. 21218 ity or Town, State  ORE MARYLAN  HOME 21231
Physician /Medical Examiner	23a. Part I. Enter the disease, or or failure. List only one cause or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	each line.	ine Toxicit quence of):	he mode of dying,	such as cardiac o	or respiratory and	DALI TIMOI	Approximate Interval Between Onset and Death
oe executed cican and mal - transit dical Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	quence of):	per me g	930 8-2	3-12 vt		
). Box 68760, the death certificate be executed by the attending physician and the for use as the burial - transit Physician/Medical Ex		23c. If yes, outcom  1 Live birth  4 Pregnant at t  9 Unknown	2 Fe	etal death 3 [	Ectopic pregna	ancy	23d. Date of de Month	elivery Day Year
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  In the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burnedical Certification: To Be Completed by Physician/Med		ns contributing to death	but not resulting in the	underlying cause gi	iven in Part I.	1 Ye 24a. Was	an 24b. We priced?	te to the cause of death?  Probably 4 Unknown  Pre autopsy findings available for to completion of cause of ath?  Yes 2 No
ion of Vital I ttending Physician: death. ctor: After this certify the funeral director, attion: To Be C	25. Was case referred to medical examiner?  1 V Yes 2 No	gation 0-ZI-I	28b. Time of 16:40p	njury 28c, Injury	y at Work? 'es 2 🗶 No	28d. Describe subject		ed toxic level
Division or Division or To the Hospital or Attending within 24 hours after death. Tn the Funeral Director: Afte completely filled in by the fune ledical Certification:		not be		rred at the time, da	te and place, and	or Town, S Gaithe due to the cau	State) 18609 rsburg, N	
To the Ho within 24 Tn the Fo completel	29b. Signature and title of certifier  30. Name and address of person w	and reanner stated.		29c. License O.C.N	number	active time, udle		(Month, Day, Year)
State Registra		Assistant Medical		/. Baltimore St	treet, Baltimo	ore, MD 212	23	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20:100 M Baby Boy Lopez-Santiago Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death MMOKE onns 8 Date of Birth (Month, Day, Year) Funeral Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Min. Hours Country) Director infant 1 X M 2 D F 10 2012 June 1 <u>Maryland</u> ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10b. Count 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 ☐ Yes 21 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 24 Carver Street 21401 TISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 1. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. Ś 1 X Never Married 2 Married ☐ Yes 2X No Maryland 21215-0036 1 🌠 Yes 2 🗆 No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed mexican Year or Dates hispanic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) infant infant infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fil f Health and Mental Item 27 Is marked and Mental ည Joel Mauro Hilia Lopez-Santiago 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 1800 Orleans Street Baltimore, MD 21287 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If Ite
any injury or ott 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state Signature of Funeral Service Licensee Rona 10, Wade, State And Address of Eaci Board 655 W. Baltimore Street rector Baltimore. MD21201 Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ PREMATURITY EXTREME disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner RESPINATONY Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit SERSIS The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 5 Other (specify) 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiclan: within 24 hours after death.

To the Funeral Director: After this certifics within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN KIM 1800 0 31. Date filed (Month, Day, Year) State 29 Registrar

rk A Luhman			ate of Maryl	and / Dep		f Health				giene		201	2 2077
Physici edical Exami		Decedent's Name (First, Middle Mark A. Luhma							2	Date of Deat Month June 26, 2	h	Year	3. Time of Death 1114 hrs
		4a. Facility Name (if not institution Harbor Hospital Center		umber)		4b. City, To		ocation of	Death			ity of Death	
Funeral Director		5. Social Security Number $216-96-2274$ Usual Residence of Decedent	6. Sex	7. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under Hours	24Hrs. Min.	8. Date of Birt		Foreig	hplace (State or n <sup>untry)</sup> Maryland
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other transmatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10a. State 10b. County  MD  10e. Street and Number  2325 Sidney A  11. Marital Status  1 Never Married 2 M	12. Was De Armed F 1 Yes orced   Yes, Give Ye or Dates: city only highest gra  College ( Last)  Luhman , hip (Type, Print ) ato / Motil	cedent Ever in U Forces? 2 x No ar ade completed) 1-4 or 5+)  Sr.  ner 20b.	16a. Deceder during m Elec  19b. Mailin 312 V Place of Dispos crematory or ot	re Cit 10f. Zip C 212 as Decedent res, specify Yes 2 X nt's Usual Or nost of workin tricia g Address Visewe ther place) Crema	ode 30 of Hispa Cuban, N No in No in 18 (Street a 11 C of ceme	Mexican, F specify: In (Give kir NO NOT us  Mother's Pris and Numbo  Ct.,	Name (F cill er or Ru	cify Yes or No- ican, etc.)	Special 16b. Kind of Elect 16aiden Surna Sauer 16ber, City or T 17 MD 2 20c. Location Glen	ace - Americal Musiness/lime) Thoff Town, State, 1227 The City or Burni	can Indian, Black,  te Industry  L Zip Code)  Town, State  e, MD
Physician /Medical Examiner	ical Examiner	23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED	on each line.  a Pulmonary  Due to (or as  b. Deep Vend  Due to (or as  c.	Thromboen	n. Do not enter t nboli of): oses of):								Approximate Interval Between Onset and Death
that the death certificate be red by the attending physici detached for use as the burit	Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Univ	23c. If yes, 1 Live 4 Preg	nant at time of de	2 Feeath 5 Of	tal death her (Specif		Ectopic p			Month		year  the cause of death?
cords, Flaw requires has been sign 2 should be	Completed by F	Part II. Other significant condit	ons contributing t	o death but not i	resulting in the i	underlying c	ause give	en in Part	_		2 No nn 24 sy med?	3 Prob	topsy findings available ompletion of cause of
Vital Recysician: The his certificate director, page	Be	25. Was case referred to medica examiner?	Hospital:	Inpatient 2 ✓	ER/Outpotion			f Death (C		ly one) Home 5	Residence 6	Other	
<b>□</b> # 2 4 3	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Penc 2 Accident Invest			28b. Time of I	njury 28	: Injury a	at Work?	2	8d. Describe h			•
Division  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: /	Certification:	3 Suicide 6 Could determine determine Suicide		ce of Injury - At h	nome, farm, stre	et, factory, o	ffice buil	lding, etc.	2	8f. Location (S or Town, St		mber or Ru	ral Route Number, City
Fo the Ho within 24 P Fo the Fur completely	Medical	one) 2 Medical Exa	nysician: To the be miner: On the basis and manner	of examination a	-						and place, an	d due to the	e cause(s)
	Σ	29b. Signature and title of certifie  200 August 1  30. Name and address of person	tale.	se of death (Iten	n 23a)		icense r D.C.M.				June 27,		nth, Day, Year)
		Carol H. Allan, MD	Assistant Medi	cal Examine		Baltimore	Street	t, Baltim	nore, N	MD 21223			
St Regis	ate trar	31. Date filed (Month, Day, Year)	Seren 32. R	egistrar's Signat									
HMH 17 Rev 1/2	001	9917 10	OCM	E	ORIGINA	L							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 23° 2012 3:40 PM Vicente Arias Lopez Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 213-78-8408 1 X M 2 □ F 56 June 28, 1955 Colombia 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 756 Quince Orchard Boulevard #201 20878 Colombia Page 1 and 2 should be filed within 72 hours after death upent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 X Yes 2 ☐ No Specify: 3 Divorced White Year or Dates Colombian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5<u>+</u> Information Technology Systems Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Dimas</u> Arias Castiblanco Blanca Delia Lopez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 756 Quince Orchard Blvd #201 Gaithersburg, MD 20878 Nancy Evans / Domestic Partner Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date \$ = 6 1 Burial 2 K Cremation 3 Removal from State Department Important: If any Injury or once, 4 Dogation 5 Other (Specify) Journey Crematory 6/28/2012 Woodbine, Maryland nal Signature of Funeral Service Licenses Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 Part 1. Enter the 1. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failere. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Liver Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Examine Due to (or as a consequence of): burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the top manification. IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🛛 No 1 ☐ Yes 2 ☐ No Yes · Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) မ 1 ☐ Yes 2 🔀 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSpice 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural 1 Yes ☐ Accident Investigation 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 6.25,2012 R143201

Registrar

DHMH 17 Rev 06-2011

State

Rockville, MD 20855

Name and address of person who completed cause of death (Item 23a) (Type, Print)

6001 Muncaster Mill Rd.

32. Registrar's signature

Debrah Miller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 June 24, 2.15 PM Marlene A. Lupton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death

BATIMONE FAULITY CATONSVILLE PARIL NURSING If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Hours Year 1947 Maryland Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Catonsville 1 🗆 Yes 2 🟋No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? "natural", or items 23a o Funeral 21228 36 Wade Ave USA 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White If Yes, Give Year or Dates Specify: 3 Divorced 4 Divorced Completed nit. Page 1 and 2 should be filed within 72 hour sartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natu injury or other traumatic event, the Medical rigury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Insurance Insurance Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Joseph Cooke Concetta Cataldi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, MD. 21228 Gary L. Lupton, husband 36 Wade Ave. 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Atlantic Cremation 1 
Burial 2 
Cremation 3 
Removal from State 06-27-2012 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ambrose Funeral Home, Inc 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ UNG CANCER UNICNOWN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner UNKNOWN ME TAS 74TIC Sequentially list conditions, if any, each g to immediate cause. Enter Underlying Examiner and -transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical The law requires that the death certificate be Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? for Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown the Unknown P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş ANEMIA Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed THROMBO CYTOPENIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check

Registrar

ANSIMDA 31 Date filed (Month, Day, Year 32. Registrar's Signature 29 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3413

29b. Signature and title of certifier

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

WILKEN AVE #204 RATIONALE AD ZILLS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ICHARD 8 2012 JUNE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore**  Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday) **Funeral** Months 76 212-32-6915 Director Aug. 12,1935 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 Yes 2 No Director Dunda1k Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code with ŏ 7865 St. Claire Lane 23a 21222 United States Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. or items 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: 9 White 3 Widowed 4 Divorced Year or Dates 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) th and Mental Hygiene.
7 is marked other than 'traumatic event, the Me College (1-4 or 5+) Elementary/Secondary (0-12) Bread Company Salesman 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn Bishoff Junior Lewis မ 19a. Informant's Name/Relationship (Type. Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ant of Health a t; If item 27 is y or other trau Dundalk, Maryland 21222 7865 St. Claire Lane Mrs. Virginia Mae Lewis 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 Donation 5 Other (Specify) Gardens of Faith Cem. 6/30/2012 Baltimore, Maryland 21. Signature of Funeral Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland De 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MOUR PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner RESPIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 4FOXIDue to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-tran Due to (or as a consequence of) resulting in death) Last Box 68760. Physician/Medical as attending IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Division of Vital Records, P.O. 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b þ 2 No 3 Probably 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No has 2 🗌 No 1 Yes Yes this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: eral Director: After filled in by the fune Natural 5 Pending investigation Injury 1 Yes 2 No death. 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 - rtifying Physican: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) pletely and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signaturé and title certifier 28,2017

State Registrar

31. Date filed (Month, Day, Year)

Service ARREIRO

32. Registrar's Signature

Lever A. January

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940 Eastern Avenue, Baltimore, MD, 21224

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Beg No. 2 1 2

		•	for State Registrar	ate of Maryland /		tificate of D		-	giene Reg. No.	2012	20775
	Physicia		1. Decedent's Name (First, Middle, Last) FJoseph		Lei	lich		2. Date of Dea Month June	Day 27,	2012	3. Time of Death 4:59 P.M
mez J	Medic Examin		4a. Facility Name (if not institution, give street a Gilchrist Hospice	nd number)		4b. City, Town, or Tows	Location of De			ounty of Death. Ba.	
	Funeral Director		5. Social Security Number 214-54-5557 6. Sex	7. Age (In yrs. last bit	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	8. Date of Birt (Month, Day	y, Year)	Cour	place (State or Foreign stry)
	and show at	ō	Usual Residence of Decedent  10a. State  10b. County	10c. City, Tov	vn or Loc	ation		<i>Dec.</i> 3			10d. Inside City Limits
	Maryla 28a-f s otified	Director	Maryland Harford		Edge	wood					1 🗌 Yes 2 🔀 No
	with the s 23a or lust be r	Funeral D	10e. Street and Number 1905 Steven Drive			10f. Zip Code 21040	)			of What Could S.A.	ntry?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	δ	1 Never Married 2 X Married 1	is Decedent Ever in U.S. ned Forces? Yes 2 No es, Give X	If	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 X No	n, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White, pecify: WI	
212-0	72 hou an "natu Medica	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	pleted)	(Give k	ent's Usual Occupa ind of work done do NOT use retired)	ition uring most of v	vorking	16b. Kind	of Business/In	dustry
212	d withir Hygiene ther than nt, the	Be Co	12 yrs  17. Father's Name (First, Middle, Last)	llege (1-4 or 5+)	Dr	iver	40.44    1.4				nitation
/lanc	d be file Mental H arked o	To	Frank Antho:	ny Leilic	h		18. Mother's I	Name (First, Middle, Pauline		Cucı	ılis
, Man	id 2 shoul salth and I n 27 is ma er trauma	1	19a. Informant's Name/Relationship (Type, Prin Mrs. April C. Leili		b. Mailin 190	g Address (Street a. 05 Steven	nd Number or Drive	Rural Route Number Edgewood,	r, City or To MD 2	wn, State, Zip ( 21040	Code)
Baltimore, Maryland 21215-0036	Page 1 ar nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	-I f CA-A- cemet	erv. crem	sition (Name of latory or other place) Service	) Ju	Date 11y 2, 20		ation - City or To	
Balt	permit. Departr Import. any inji	j	21. Signature of Funeral Service Licensee	och h				Baltimore, Inc. 53	_		
j	hysician/	8	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Immediate Cause (Final disease or condition	s that caused the death. Do e on each line.	not ente	r the mode of dying			est,		Approximate Interval Between Onset and Death
	Medical Examiner			Due to (or as a consequence	of):		0				
	ed	Examiner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	oue to for as a consequence	rot):						
	cate be executed physician and s the burial-transit	al Exa	that initiated events c. —	Due to (or as a consequence	of):						
8760	ificate bing physical as the t	Medical	d								
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Honoral Attendeath.  The Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnancy  Live Birth 2  Fetal dea: Pregnant at time of death Unknown		Ectopic pregnancy Other (specify)	/		23	d. Date of deliv Month	ery Day Year
s, P.O.	ires that the signed by Id be deta	þ	Part II. Other significant conditions contributions	ng to death but not resulting	in the ur	nderlying cause give	en in Part I.	23e. Did to			ne cause of death?
ecord	he law requ te has beer age 2 shou	Completed						24a. Was a autop		24b. Were auto prior to co death?	psy findings available mpletion of cause of
Ital	ician: T certifica rector, p	Be	25. Was case referred to medical examiner?			Other	r-	heck only one)			A. 13
Division of Vital Records,	nding Phys ath. r: After this ie funeral di	icate: To	1 Ves 2 No Hospita  27. Manner of Death 1 Natural 5 Pending 2 Ascident Investigation		Time of injury	28c. Injury work?	4 ∐ Nursin at	g Home 5 Resid			Hospice
DIVISIO	al or Atte s after de: al Director ed in by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	. Place of Injury - At home, for building, etc. (Specify)	arm, stre	et, factory, office		28f. Location (S City or Tow		lumber or Rurai	Route Number,
	ne Hospit in 24 hour ne Funera pletely fill	Medical		o the best of my knowledge, the basis of examination and/ itioner: To the best of my kno	or investi	gation, in my opinior	n, death occurr	ed at the time, date a	nd place, ar	nd due to the ca	use(s) and manner stated.
	To the Common Co		29b Signature and title of certifier	M.A.		29c. License		7	-	28-1	
	1300		30. Name and address of person who complete	ed cause of death (Item 23a)	(Type, Pi			Baltine			1204
	Stat Registra		31. Date filed (Month, Day, Year) JUN 29 2012 Lenur	32. Registrar's Signature	ALA		/		<u> </u>	-0 0	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** AM 6:55 2012 27 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year | Months Days 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F 235-30-1254 Mt. Clare, WV 88 March 16, 1924 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 Yes 2X No Directo Dundalk Baltimore Maryland 10e, Street and Number 10f. Zip-Code 10g. Citizen of What Country? be filed within 72 hours after death with ntal Hygiene. 21222 USA 4 A Northship Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 14. Race - American Indian 11. Marital Status Black, White, etc. ☐ Yes Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**No Specify. ģ Specify: White 3 ₩ Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Johns Hopkins Bayview Elementary/Secondary (0-12) L.P.N. 12 years 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, Be Pages 1 and 2 should be nent of Health and Mental is marked Millie Welch Braxton Lee Rinehart မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 Eastship Road, Dundalk, Maryland 21222 Department of Health a Important: If item 27 is any Injury or other trainonce. daughter Nancy D. Loiacono 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2012 21. Signature of Fundral Service License 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 21222 Thone 00 23a. Part 1. Enter the disease corcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumoni dou disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician d for use as the buri Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant was decedent progrin the past 12 months?
1 ☐ Yes 2 No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the al 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes ate has been sig.; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 2 No 2 No or Attending Physician; 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 1 ☐ Yes 2 XNo Other:  ${}_{4} \square$  Nursing Home  ${}_{5} \square$  Residence  ${}_{6} \square$  Other (Specify) မ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: s after death. 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗆 No 2 Accident 3 
Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral D Hospital 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated. To the within 2 29b. Signature and title of certifie RES-000

DHMH 17 Rev 1/2001 11595

State Registrar 4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Scott Miskimon 26 7:14 Α. June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Joseph Medical Center Towson Baltimore Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** Min (Month, Day, Year) Director 213-46-0589 1 🛛 M 2 🗆 F 65 Oct. 26, 1946 Maryland show 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2X No Maryland Baltimore Baltimore ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21234 1910 Glen Keith Blvd. U.S.A. items death v 12. Was Decedent Ever in U.S.
Armed Forces?
1 X Yes 2 □ No
If Yes, Give
Year or Dates. 1966–1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 0 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 👿 No Specify "natural", Specify: 3 Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Insurance Sales vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental F marked of မ Carrol1 Miskimon Eunice Storke and lis ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 1910 Glen Keith Blvd. Baltimore, Maryland Josephine Miskimon (wife) 21234 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 5 <u>=</u> 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 6 - 30 - 12Metro Crematory, Inc. Baltimore, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
5500 York Road Baltimore, Maryland ena 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) ongestive Medical 54n. Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death a | Unknown signed by 1 Id be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 performed Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 28 NICK MELLI D0047162 20 30. Name and address of person who con d cause of death (Item 23a) (Type, Print) Nick Mellis, 2352 York Road M.D. Timonium, MD 31. Date filed (Month, Day, 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

Physicia Medic Examine	al
Funeral Director	

For State Registrar

Forest Hill Health & Rehab Center  Forest Hill Heal	9. Birthplace (State or Foreign Country)  MD  10d. Inside City Limits  1  Yes 2 No  n of What Country?
Funeral Director 5. Social Security Number 2.18 – 2.2 – 1.569	Country) MD  10d. Inside City Limits 1
Director 218-22-1569 1   M 2   XF   83   Yrs.     05/21/1929	MD  10d. Inside City Limits  1 □ Yes 2 □ No n of What Country?  Race - American Indian,
purple with the way of	1 ☐ Yes 2 No n of What Country?  Race - American Indian,
The second of th	n of What Country?
809 Gary Drive 21087 USA  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
က္ခြား ခြင့္မြင့္ မြင္တို႔ 1 ⊔ Never Married 2 ⊔ Married   1 □ Yes 2 Ϫ No	Black, White, etc.
The second secon	ecify: White
Specify only highest grade completed)    College (1-4 or 5+)   Col	of Business/Industry
College (1-4 or 5+)  Receptionist  Hot	cel
Tr. Father's Name (First, Middle, Last)  William Birch  18. Mother's Name (First, Middle, Maiden Sun  Ethel Gill	na <i>me</i> )
The Never Married 2   Married 1   Yes 2   X No   1   Yes 2   X No   1   Yes 2   X No   No   Year or Dates.   1   Yes 2   X No   Year or Dates.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   Specify only highest grade completed.   1   Yes 2   X No   Specify:   1   Yes 2   X No   Yes 2	wn, State, Zip Code) 087
20a. Method of Disposition Son-in-Law 20b. Place of Disposition (Name of cemetery, crematory or other place)  1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Schimunek Funer	ntion - City or Town, State
Second Property   Second Pro	no, MD
21. Signature of Funeral Service Licensee  22. Name and Address of Facility Schimunek Funer  610 W. MacPhail Rd., Bel Air,	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician/ Medical disease or condition resulting in death)  Immediate Cause (Final disease or condition resulting in death)  Sulf street demaid:  Due to (or as a consequence of):	Onset and Death
Examiner	
Sequentially list conditions, If any leading to in reclate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
dical dical	
d	d. Date of delivery
23c. Was decedent pregnant in the past 12 months? 1	Month Day Year
o the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II.	contribute to the cause of death?
1   Yes 2	No 3 Probably 4 Unknown
The law requires the la	24b. Were autopsy findings available prior to completion of cause of
The second of th	death? 1 Yes 2 No
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:	Other (Specify)
To the state of th	ocurred
28d. Describe how injury or injury at work?  28d. Describe how injury at work?	lumber or Rural Route Number,
Sign of the state	
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatient   3   DoA   Other: 4   Nursing Home   5   Residence   6    27. Manner of Death   1   Inpatient   2   ER/Outpatient   3   DoA   Other: 4   Nursing Home   5   Residence   6    28. Date of injury   28b. Time of injury   28b. Time of injury   28c. Injury at work?   1   Yes   2   No   28c. Injury at work?   28c. Injury at wo	nd due to the cause(s) and manner stated
	signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	25,20/2
State Registrar  State  JUN 29 2012  August A. Agasta	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland , Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Billy H. Mack 11:10 AM Medical 12 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N?A Examiner Sentinal Assistance Living Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 10/22/45 411-76-1400 Country)
TN 65 Director 1 🔀 M 2 🗆 F Yrs 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Madical Examiner must be notified at 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo N/A Baltimorer MD Baltimore 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 21212 10g. Citizen of What Country? 901 Woodbourne Ave Funeral USA 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No African Specify: Amer. 1 K Never Married 2 Married ģ Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🖾 No Specify 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Construction Construction Construction (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer 12 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mente Important: If Item 27 is marked any injury or other transpore ည Dorothy Brown Vatin Mack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
n 901 Woodbourne Ave, Balt., MD 212121 Rodney McCoy/Legal Guardian Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 6/29/12 Balt., MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hari P. Close F. Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Priysician/ rostate adenocarchoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to jor as a consequence of attending physician end I for use es the burlal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death
9 Unknown ed by the a detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed to should be det 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Cerebrovascular accident 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 Yes 2 No Division of Vital ospital or Attending Physician: hours after death. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No |은 1 Inpatient 2 ER/Outpatient 3 DOA this 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 ☐ Yes 2 ☐ No Director: A id in by the f 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide hin 24 hours after the Funeral Dires mpletely filled in b To the Hospital Medicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the I

complete 29b. Signature and title of certifie 29c. License number 056211 and address of person who completed cause of death (Item 23a) (Type, Print) 3001 ZOWIN MA 1791010 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 Registrar DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Physician/ 5:30 A.M June Margaret Speno Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days (Month, Day, Year) Hours Country) 220-44-8451 Director 1 ☐ M 2XXF Feb. 24, 1938 Florida 74 Usual Residence of Decede 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Tyes 2 XXVo Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21074 U.S.A. 3820 Normandy Dr., Unit 3B 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. \$ 1 Never Married 2XX Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns any injury or other traumatic events." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Teacher Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis G. Speno Margaret Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3820 Normandy Dr., Unit 3B, Hampstead, MD 21074 Alfred R. Martin (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State All Faiths Crematory
& Chapel 1 ☐ Burial 2XXCremation 3 ☐ Removal from State 6/29/2012 Manchester, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune pail Service Licens 22. Name and Address of Facility Eckhardt Funeral Chapel, 3296 Charmil Dr., Manchester, MD 21102 nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Monari disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate Cause (Disease or injury Due to (or all a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? À ate has been signe page 2 should be 1 Yes 2 No 3 Probably 4 Unknown demente Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 \(\sigma\) No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

P.O. Box 68760 Records. Division of Vital ie Hospital or Au.
in 24 hours after death.
in Director: A' To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu

Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 N. Charles nor Registrar's Signat State Registrar

12-04760		ease Type o							egible	<b>)</b> .			
Donte L. Moore, Sr	1- For State Registrar		of Marylar			of Health and of Death	nd Mental		Reg. No.	20	12 207		
Physician/ Medical Examine	Donte Lamo	nt Moore Si						Month June 24	Day	Year	3. Time of Death 2002 hrs		
	4a. Facility Name ( Bon Secou	if not institution, giv rs Hospital	e street and num	ber)		4b. City, Town, of Baltimore	or Location of Dea	ath	40	. County of Dea	th		
Funeral	5. Social Security I			. Age (In yrs. la	st birthday)	If Under 1 Ye		lin	,	Fore	irthplace (State or		
Director	220-90-428 Usual Residence of		M 2 F	35	- Yr		yo Hodio II	05/17	/1977		ountr <b>M</b> D		
ом апу	10a. State	10b. County		10c. City, 1	Fown or Loca						10d. Inside City Limits 1 X Yes 2 No		
the Maryland a or 28a-f show any tified at once. Director	MD 10e. Street and Nu	n/a			Ba	ltimore 10f. Zip Code			10g. Citiz	zen of What Co			
ith the M 23s or 2 notified		on Street				212			US				
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 Never Marri	ed 2 Married	A	dent Ever in U.Sces? 2X No		as Decedent of H Yes, specify Cuba			No-	14. Race - Ame White, etc.	erican Indian, Black,		
ural", o	3Widowed	4 Divorced	If Yes, Give Year		16a Decede	Yes 2 X N	o specify:	of work done		Specify: Blac			
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5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	12 17. Father's Name	(First, Middle, Last)				Disabled		ne (First, Middle		sabled Surname)			
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica. To Be Complé	Thomas Mot	inley Moon						omasina W					
MD 21 tid 2 should alth and Me m 27 is ma aumatic ev	1	9a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip  825 North Port St Baltimore, MD 21205											
Baltimore, ME permit. Pages I and 2 s Department of Health at Important: If item 27 injury or other traum		Oa. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  20c. Location - City or Tow crematory or other place)  Consider Cremation  Date  20c. Location - City or Tow crematory or other place)  Consider Cremation  Date  20c. Location - City or Tow crematory or other place)											
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	4 Donation 5 21. Signature of Fu	Donation 5 Other South											
	23a Part Enter th	4517 Park Heights Ave Baltimore, MD 21215											
Physician (Medical Examiner		ly one cause on ea							11631, 3110	ck, of fleat	Approximate Interval Between Onset and Death		
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iner	Sequentially list co if any, leading to in cause. Enter Under	mediate	Due to (or as a co	onsequence of):									
ted Insit Examiner	(Disease or injury t events resulting in	death) Last	Due to (or as a co	onsequence of):		-							
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Box 68760, death certificate be eath attending physicia of for use as the burianty sician/Medi	IF FEMALE: 23b. Was decedent		23c. If yes, ou	tcome of pregna	. —	etal death 3	Ectopic preg	nancy		. Date of delive	ry Day Year		
D. Box 6 true death cer by the attendiached for use.  Physicia	past 12 months		4 Pregnan	t at time of deal	- I	ther (Specify)							
ires that the case of the detached the detac	Part II. Other signi	ficant conditions			ulting in the	underlying cause	given in Part I.				the cause of death?		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that th rs after death.  **Indicator: After this certificate has been signed by led in by the funeral director, page 2 should be detach errification: To Be Completed by Perification: To Be Completed by P								1 Y			utopsy findings available		
Records,  The law requires ficate has been signage 2 should be Completed				_				perl	opsy formed? 2 No	death?	completion of cause of		
ital Recition: The sertificate rector, page	25. Place of Death (Check only one)												
n of Vision Physical differential differenti	1 V Yes 2 No 2 No 28 Departs 1										er; 		
Division o spital or Attending nours after death.  neral Director: Affilled in by the fune	1 X Natural 2 Accident	5 Pending Investigation	on		6		Yes 2 No	Oof Leasting	(0)		I B I M I D O		
Divisior Hospital or Attend 24 hours after death Funeral Director: retely filled in by the	3 Suicide 4 Homicide	6 Could not determined	oe	or injury - At non	ne, rarm, stre	et, factory, office	building, etc.	or Town,		nd Number or R	ural Route Number, City		
E   F 24   6	29a. Certifier (Check only one)	Certifying Physici Medical Examiner		-									
To the within To the comple comple	29b. Signature and		and manner stat			29c. Licen					onth, Day, Year)		
1010	U-~	<u> </u>	amalat T			O.C.	.M.E.		June	25, 2012			
Danis	30. Name and addr Donna M. V		Assistant Me	dical Exami	ner 900	W. Baltimore	e Street, Balt	imore, MD 2	1223				
State	31. Date filed (Mont	th, Day, Year)	32. Regis	strar's signatur	arke			-					

12-04623 Joseph Oxendine

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2012 20782 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1642 hrs **Medical Examiner** Joshua Burnell Oxendine June 19, 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4331 East Lombard Street Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 7. Age (In yrs. last birthday) 9. Birthplace (State or 5. Social Security Number **Funeral** oreign Country Maryland Months Days 31 Yrs May 16, 1981 Director 214-98-9678  $_{1}XX_{M}$ 2 F Usual Residence of Decedent Oc. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 XXNo Dundalk Maryland Baltimore s 23a or 28a-f show notified at once. ges I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28a-f she ther traumatic event, the Medical Examiner must be notified at once Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7281 Bridgewood Drive 21224 United States Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Armed Forces? Yes American Indian 1 Yes 2 XX No specify: 4 Divorced If Yes, Give Year 2 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Manufactory / Elementary/Secondary (0-12) MD 21215-0036 Construction Forklift Operator 12yrs N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Sandra Gayl Oxendine Gary Michael Milligan 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Gayl Oxendine/ Mother 7281 Bridgewood Dr., Dundalk, Maryland 21224 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition timore, crematory or other place) permit. Pages 1 Department of H Important: If it 1 XX Burial 2 Cremation 3 Removal from State Loudon Park Cemetery June 25,2012 Baltimore, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility AMBROSE FUNERAL HOME, INC. ignati re if Funeral Service Licensee 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 aluxa ana 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and Medical Death a Heroin and Alcohol Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical Mended #1 as noted, per me, g928 6-29-12 sm 23a, pt. II, 27, 28a-f, per me, g929 7-2-12 s e attending physician for use as the burial -X UNPENDED 3a.pt.II.27.28a-f.per me.g929 Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? After this certificate has been signed by funeral director, page 2 should be detacht <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Cocaine Use Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25 Was case referred to medical BB Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 5 Pending 1 Yes 2 X No unknown within 24 hours after death.

To the Funeral Director: the fd 6-19-12 unknown 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4331 East Lombard St 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be (Specify) Found: Residence 4 Homicide Baltimore, MD 29a. Certifier 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. June 20, 2012 30. Mame and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Russell Alexander MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar **OCMF** 

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1 - For State Registrar		Cer	tificate of	Death	Wientarity	Reg. No. 2	)   2	2078
Physician/		arwood Watkins	Owings,	Jr.		2. Date of De Month Ju	ath un 28ay <b>2</b> 012	2 Year	3. Time of Death 2:40 AM M
Medical Examiner	4a. Facility Name (if not institu	tion, give street and number) ontgomery Medical Cer	nter	4b. City, Town, o	r Location of Deal	th	4c. Count	y of Death <b>Montg</b>	omery
Funeral Director	5. Social Security Number 183-18-5623	1 M 2 🗆 F	yrs. last birthday) <b>90</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birth Cour	place (State or Foreign htry) MD
laryland 3a-f show tified at	Usual Residence of Deceder 10a, State MD		c. City, Town or Lo	cation	Highland				10d. Inside City Limits 1 ☐ Yes 2 No
leath with the Maryland items 23a or 28a-f sho ler must be notified at Ermust be Diffect or Funeral Director	10e. Street and Number 13009 Highland R	oad		10f. Zip Code	20777		10g. Citizen of	What Cou <b>U.S.</b>	ntry?
P - 19	11. Marital Status  1 Never Married 2	I IVAC Civo		Was Decedent of I f Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Ra Bla Specit	ce - Americack, White, Whi	
d Z1Z13-0030 ed within 72 hours after c Hygiene. other than "natural", or ent, the Medical Examin Be Completed by		edent's Education ighest grade completed)  12) College (1-4 or 5+)		dent's Usual Occu kind of work done O NOT use retired		orking	16b. Kind of	Business/Ir Govern	
be filed wental Hyge ental Hyge ked othe ic event,		lle, Last) Harwood Watkins Owi	ings Sr.		18. Mother's Na	ame (First, Middle,	, Majden Surnar Orthea Mo	ne) ore	
Maryland 12 should be filed afth and Mental Hy 27 is marked off r traumatic event	19a Informant's Name/Relati	onship (Type, Print) Son In Law	19b <b>1 M</b> aili	ng Address (Street 6 Lombard	Drive Ellico	tt City, MD	21042 Town,	State, Zip	Code)
Baltimore, permit. Page 1 and Department of Heal Important: If item 2 any injury or other once.	20a. Method of Disposition  1	tion 3 Removal from State	20b. Place of Dispo cemple very Atlantic	osition (Name of Crematory, L	ුළු Jui	Date 29, 2012	20c. Location <b>G</b>	า - City or T len Bur	own, State rnie, MD
balti permit. Departr Imports any inji	21. Signature (Fune Serv	the Lice fee most	551 22	2. Nam <b>SlackdFi</b> 3871 Ol	anerai⊪Home, d Columbia P	P.A. ike Ellicott C	ity, MD 210	43	
Cate be executed cate be executed bhysician and sthe burial-transit sthe burial-transit called Examiner		a. Due to (or as a co	nsequence of):	ARDIO		HJ VISEAGE			4554
		23c. If yes, outcome of p  1  Live Birth 2   4  Pregnant at tim 9  Unknown	Fetal death 3	☐ Ectopic pregnal☐ Other (specify)	псу			Date of deli	very Day Year
s, P.O. BG res that the dea signed by the a d be detached to	Part II. Other significant cor	nditions contributing to death but n	ot resulting in the	underlying cause (	given in Part I.				the cause of death? obably 4 $\square$ Unknow
The law requires cate has been signage 2 should be completed	HYPER L	MÉLITUS 10103m/A				perf	s an 24b opsy formed? 2 P No	prior to c death?	opsy findings available ompletion of cause of
Nysician: Physician: this certifical director	25. Was case referred to med examiner?  1  Yes 2 No	Hospital:  1 Minpatient  28a. Date of injury	2 ER/Outpatie 28b. Time of injury	ent 3 DOA Of		Home 5 Res	sidence 6 0 0 how injury occu		fy)
DIVISIC Ital or Atter ins after des al Director led in by the	3 Suicide 6 C 4 Homicide de	ould not be etermined 28e. Place of Injury - building, etc. (S	Specify)			City or To	iwn, State)		al Route Number,
To the Hospital or Attending Is within 24 hours after cleath.  To the Funeral Director: After completely filled in by the funeral Madrical Certificate	Check 2 Medi	fying Physician: To the best of my cal Examiner: On the basis of exam fying Nurse Practitioner: To the be	nination and/or inve	stigation, in my opi e, death occurred a	nion, death occurre	ed at the time, date	and place, and	d manner as	ause(s) and manner states stated.
P ≥ ≥ 0	> Eur	^ /	h (Itam 23a) (Time				_		
State	EVELYN JA	Harry mp 55 par) 32. Registrar's	40 TEN	DAKES 1	n com	isi u	= mn	210	29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ferr J Wonth e 8:26 Physician/ 2512 Marian Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Balk more If Under 1 Year | If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 219-40-906 68 1 M 2 F Director 10d. Inside City Limits 10c. City, Town or Location with the Maryland notified at **Funeral Director** 1 Yes 2 No 28a-f more 10g. Citizen of What Country? ö r must be r 2122 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black White etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Completed 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Be <u>\_</u> ype, Prin (Daughter (Street and Number or R 19b. Mailing Address Method of Disposition Burial 2 Cremation 3 Remo Other (Specify) 5 L 4 Donation complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Part 1. Enter the shock, or hear disease, or 23a, Part 1. failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Intershipal lung Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be us within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nahvairals. Division of Vital Records, P.O. Box 68760 the 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: Medical Certificate: To 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at injury work? 1 \square Yes Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year, 06/27/2012 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elshazly 21287 Mohamed Balxmore MP 1800 Orleans 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DIZIENNE 2:50AM 06 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITA BALTIMORY Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Days (Month, Day, Year) 218-62-5753 **Director** 1 ☐ M 2X F 58 Jan 1, 1954 Maryland Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Brooklyn 1 Yes 2 No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a216 Elizabeth Avenue 21225 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, traumatic event, the Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 ▼ No Specify. 'natural", 3 Widowed 4 Divorced Specify: black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 private duty nursing healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ann Phillips 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
216 Elizabath Avenue Brooklyn, MD 21225 19a. Informant's Name/Relationship (Type, Print) of Health a item 27 i REginald Pinder/spouse 216 Elizabath Avenue Brooklyn, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Page 1 Department of Important: If it any injury or or once. 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify) in state Romald S. Vede Sign 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD Patr 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CANCER disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events and as the burial-trai Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) \_\_\_\_ Į in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 L 2 No g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 Tother (Specify) HOSPICE Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce 129807

State Registrar STE 106

. Registrar's Signature

1406 S.CRAIN HUY GLEN BURNIE, MA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meis

0-21GEC

29

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Per FH G929 7/10/2012 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26<sup>Day</sup> 2012<sup>Year</sup> Physician/ JUNE 10:15 AM PEOPLES **ESTHER** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S 7613 RIVERDALE RD # 106 NEW CARROLLTON Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 55 **Director** 578-80-6028 1 M 2 X F FEB. 6 1957 NORTH CAROLINA Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland Director notified at 1 X Yes 2 ☐ No NEW CARROLLTON PRINCE GEORGE'S MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō must be r Funeral 20784 USA 7613 RIVERDALE ROAD # 106 'natural", or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 BLACK 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) Hydiene PRIVATE **CLERK** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F MATTIE PEOPLES ALSTON TIDIE other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 5420 A.GRIST MILL COURT SOUTH FT. BELVOIR permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau VA 22060 5420 A. GRIST MILL SHENEKA SIERRA/DGT Baltimore, 20b. Place of Disposition (Name of Hertilage of Memorila) lceCem. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RESURRECTION CEMETERY 7/6/2012 CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee Raphney 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death · Ph, sician/ Immediate Cause (Final METASTATIC BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical death certificate be P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
g Unknown for Month Day Year 5 Other (specify) Hospital or Attending Physician: The law requires that the ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signt 1 be c þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 Yes 2X No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4  $\square$  Nursing Home 5X Residence 6  $\square$  Other (Specify) Hospital 2 X No ဂ္ဂ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 \( \sum \) Yes 2 \( \sum \) No 1X Natural 5 Pending 24 hours after death.

e Funeral Director: A:
sletely filled in by the fi Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) Kouertchesu, mo Joletyne 163748 JUNE 28, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20705 JOCELYNE KOUATCHOU M.D. 4041 POWDER MILL ROAD # 600 CALVERTON, MARYLAND 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 29 2012

DHMH 17 Rev 06-2011

Registrar

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Ma	ryland		ırtmeni <i>tificate</i>			and IV		- /	2010	) )	0.7	197
			Registrar  1. Decedent's Name (First, Middle, Last)			Cei	incate	010	caiii		2. Date of Dea	Reg. No.	2012	3. Tir	ne of De	eath
	Physicia Medic		NKENGE CLARA	POINDE	XTER						Month JUNE	26	$201^{\text{Year}}_{2}$		00	P <sup>M</sup>
	Examin		4a. Facility Name (if not institution, give sa	reet and number)			4b. City, T						ounty of Deat			
کرد.			HOLY CROSS HOSPIT  5. Social Security Number 6. Sex		(In ure las	st birthday)	SIL\		SPRIN If Under:		8. Date of Birtl		ONTGOM			To see for a
	Funeral Director			M 2 🗓 F			Months	Days	Hours	Min.	(Month, Day	, Year)	Co	hplace (Si		
	, MC		Usual Residence of Decedent		4(						OCT 7,	19/1	CA	LIFOR		
	ryland I-f sho ied at	Director	10a. State 10b. County  MARYLAND HOWARD			Town or Loc AUREL	ation							10d. Insi	de City∣ ∛Yes 2	
	he Ma or 28a notif		MARYLAND HOWARD  10e. Street and Number		11	AUKEL	10f. Zip	Code		<del></del>		10a. Citize	en of What Co		1 163 2	
	with t	Funeral	9200 LIVERY LANE A	T. A			20	0723				-	ITED S			
	death items ner m		TH Maritar Oracoo	Was Decedent Ev Armed Forces?	er in U.S.	13. V	Vas Decede Yes, speci	ent of Hisp	panic Orig	jin? (Spe	cify Yes or No- Rican, etc.)	14	. Race - Ame Black, White		ın,	
36	after al", or xamii	d by	1 ☐ Never Married 2 🛛 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give	0		☐ Yes 2					Sp	pecify: BLA			
ž	hours natura lical E	lete	15. Decedent's Edu	Year or Dates.		16a. Deced					1	16b. Kind	DLF of Business/			
7	be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	Completed	(Specify only highest grad	College (1-4 or 5+		life. DC	ind of work NOT use	retired)	ring most	of workir	ng I					- 11
72	dygier Hygier Ither t	Be C	17. Father's Name (First, Middle, Last)	4		IT SI	PECIA		10 M-4-	u-t- NI	(First, Middle, i		ERAL GO	OVERN	MEN'	<u>T</u>
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	2	CARL SIMS	S				- 1	CLARA		(First, ivildale, i		ASON			
ary	2 should be Ith and Ment 27 is marker r traumatic e		19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailin	g Address (	(Street an	nd Numbe	r or Rurai	Route Number	City or To	wn, State, Zip	Code)		
	1 and 2 s of Health item 27 other tra		FABIAN O. POINDEXTI	ER/HUSBAND		9200 I	LIVERY	Y LAI	NE AP	т А,	LAUREI	, MAI	RYLAND	2072	.3	
Baltimore,	- 4 = 0		20a. Method of Disposition 1 X Burial 2 Cremation 3 ☐ F	emoval from State		ace of Dispos metery crem LOWER CH CE1	sition (Name natory or off METER)	e of he <b>r plac</b> e,	)		ate		ation - City or			
III	Pa ant ant		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		CHUR						JENKINS		ALIE,			
Ra	permit. Departr Imports any inji	- /	Nachney N.	Cornol	$HI\Delta$						HYATTS			-		
			23a. Part 1. Enter the disease or compli shock, or heart failure. List only one	cations that caused to	he death.									Approx		==1
	Phynician/	8 4	Immediate Cause (Final disease or condition	METASTAT	CIC C	COLON (	CANCE	R					37		and Dea	
	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):										
Ž,		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	conseque	ence of):										
	uted Id ransit	Examiner	Cause, Enter Underlying Cause (Disease or injury that initiated events													
	e executed sian and urial-transi	E E	resulting in death) Last	Due to (or as a	conseque	ence of):										
9	certificate be executed nding physician and use as the burial-transit	edical				-										
200	certific nding use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23	Bc. If yes, outcome of								23	d. Date of del	iverv		
Box 68	law requires that the death certificans been signed by the attending for 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 🗓 No	1 Live Birth 2 4 Pregnant at t 9 Unknown			Other (spe						Month	Day	Yea	ır
7. O	at the		9 ☐ Unknown  Part II. Other significant conditions con		not resul	Iting in the ur	nderlying ca	ause dive	n in Part I		220 Did to	baaaa una	contribute to	the equipe	of doot	th?
λ. J.	ires thi signed	d by	Tarin out of significant contains to	and and an action of		iang in aro ar	idony.ing or	g.v.c					No 3 P			
ord	v requires s been sig	olete									24a. Was a		24b. Were aut	opsy findi	ngs ava	ilable
or vital Records,	he lav rte has page 2	Completed									autop perfor 1  Yes	med?	death?	ompletion 2 $\square$ No		se of
ē	cian: T	BeC	25. Was case referred to medical examiner?	-				T	e of Deat	h (Check		2 <b>A</b> . 110	7 1 100	2 111		
	Physic this corral dire	မ	1 ☐ Yes 2 🔀 No H	ospital: 1 X Inpatier 28a. Date of injury		R/Outpatien		_	4 ∐ Nu		me 5 Resid			fy)		
ם ב	ding th. After fune	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day,		injury	M 28	c. Injury a work? 1 \Bar Y	es 2 🗍	- 1	8d. Describe ho	ow injury o	ccurred			
DIVISION	Atter er dea ector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury		ne, farm, stre				-	28f. Location (S		lumber or Rui	al Route N	lumber,	
Ž	ital or ars after ral Dir			building, etc.							City or Towi					
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 X Certifying Physic Check 2 Medical Examine	r: On the basis of exa	mination a	and/or investi	gation, in m	ny opinion	, death oc	curred at	the time, date ar	nd place, ar	nd due to the o	ause(s) an	d manne	er stated.
_	Fo the within Fo the somple	Σ	only one) 3 L Certifying Nurse 29b. Signature and title of certifier	Practitioner: To the	oest of my	y knowledge,		License r	_	e and plac			and manner a		r)	
D			MM 9					D6991	19			JUNI	E 27,	2012		
	5001		30. Name and address of person who co	•		, , , , , ,				95-		-				
	- CW		NIOKE WRIGHT, M.D  31. Date filed (Month Day, Year)					, SII	LVER	SPRI	NG, MAR	YLANI	20910	)		
	Stat Registra		III 29 2012	2. Registrar	Ø.	Mar	Car									

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland	-	artment of I			giene Reg. No.	2 20700	
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Yea	3. Time of Death	
. 20	Physicia /Medic		JAMES	PAYNE				JUNE 2	5 2012	5:36 A M	
	Examin	er	4a. Facility Name (If not institution, give s 306 E. TANTAL).			4b. City, Town,			4c. County of D		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	last birthday)	If Under 1 Year	ASHINGT	Irs. 8. Date of Bir	th 9.1	GEORGE S Birthplace (State or Foreign	
M.	Director	į.	217-35-3783	M 2□F	20 Yrs.	Months Days	Hours N	Min. (Month, Da APRIL	20 1992 MA	Country)	
	nud *	2	Usual Residence of Decedent  10a. State 10b. County	10c. City	y, Town or Lo	cation				10d. Inside City Limits	
	Maryla f sho	by Funeral Director	MARYLAND PRINCE G			SHINGTON				1 X Yes 2 □ No	
	r 28a-		10e. Street and Number	dollon b	OICI WII	10f. Zip Code			10g. Citizen of What	Country?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatil and Mentall Hygiene. Important: If tien Z7 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		306 EAST TANTALLON	DRIVE		20744			UNITED ST	CATES	
			11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of I	Hispanic Origin?	(Specify Yes or No uerto Rican, etc.)	- 14. Race - A Black, W	merican Indian, /hite, etc.	
36			1 X Never Married 2 Married 3 Widowed 4 Divorced	1  Yes 2  No If Yes, Give Year or Dates:		1 □ Yes 2 ሺ No	Specify:		Specify:	BLACK	
21215-0036		ed k	15. Decedent's Educ	cation	16a. Dece	dent's Usual Occu	pation		16b. Kind of Busine		
215		To Be Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give life.	kind of work done DO NOT use retire	during most of ed)	working			
2				1	NON	E	140.14.11.11	- (F) - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	NONE		
			17. Father's Name (First, Middle, Last)	DANNE			VONDA:	Name <i>(First, Middle,</i>	·	CV	
Ž			ANTHONY BOUCREE  19a. Informant's Name/Relationship (Type)	PAYNE	19b. Mailir	ng Address (Stree	1		HARDRI er, City or Town, Stat		
			ANTHONY B. PAYNE /	FATHER					SHINGTON,		
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Re	amoval from State	tace of Dispo	sition (Name of matory or other pla	ace)	Date	20c. Location - City	or Town, State	
<u>E</u>	Pages ment of I ant: If ite lury or or		4 □ Donation 5 □ Other (Specify)			E CREMATO		03/2012		E, MARYLAND	
Ball	Departm Departm Importar any Injur once.		21. Signature of Funeral Service License	100000 Aire	~	2. Name and Addr				CRAL HOME, INC.	
			23a. Part1, En er the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate								
	cian: The law requires the entificate has been signed ector, page 2 should be control.		shock, or heart failure. List only one cause on each line.  Interval Between Onset and Death  Onset and Death								
			disease or condition resulting in death)	Due to (or as consequ	uence of):	olasm o	t brain	1		- 4 years	
		iner	Sequentially list conditions b								
			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that injurated events								
		Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):							
760,		calE									
89		To Be Completed by Physician/Medi					_				
XOX			IF FEMALE: 23b. Was decedent pregnant 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pre				c pregnancy		23d. Date of delivery  Month Day Year		
P.O. Box						Other (specify)					
<u>п</u>			Part II. Other significant conditions con	ntributing to death but not resu	ulting in the u	nderlving cause gi	ven in Part I.	23e. Did t	tobacco use contribut	e to the cause of death?	
Records,									1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ l		
							24a. Was	an 24b. Were	24b. Were autopsy findings available		
æ							_ perfo	autopsy prior to completion of caus death?  1  Yes 2 No 1 Yes 2 No			
Division or Vital			25. Was case referred to medical examiner?					Death (Check only o			
			1 ☐ Yes 2☐ No		" 3 DOX	74		sidence 6 Other (Specify)			
			27. Manper of Death  1  Natural			of 28c. Injury at 28d. Descri Work? M 1 ☐ Yes 2 ☐ No			be how injury occurred		
/ISI		fical				eet, factory, office 28f. Location			(Street and Number or Rural Route Number,		
		Medical Certification:	4 ☐ Homicide determined building, etc. (Specify)					City or To	City or Town, State)		
			29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To th within To th comp	Me	29b. Signature and title of certifie	MAD MAD		29c. Licen	se number		29d. Date signed (M		
	MA		Jay Mgg	man, mo		025	1000		06-27-1	12	
	5 8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JAY LIPMAN MO 9200 BASIL CT LARGO MO 20774								
	Sta Registr		31. Date filed (Month, Day, Year) JUN 29 2012	32. Registrar's Signal	ture						

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ronnie McKin	ley P	1- For State Registrar				irtment of tificate of	f Health and f Death	d Mental H	R	eg. No. 2	12 2078		
Physi Medical Exa		RONNIE	MCKINI	LEY	PEOPLE				2. Date of Dea Month June 23, 2	Day Year 2012	3. Time of Death 2131 hrs		
		Facility Name (if not Prince Georges     Social Security Numbers	Hospital		ber) . Age (In yrs. Ia		4b. City, Town, or L  Cheviery  If Under 1 Year	cocation of Death Cheverly If Under 24Hrs		4c. County of Prince Ge	orge's		
Funer Directo		579-72-1435	1 🗓 1	M 2 F	- , -	56 Yrs	Months Days	Hours Min	_	F	9. Birthplace (State or		
und show any	- Le		County RINCE GI	EORGE'S		Town or Locat					10d. Inside City Limits 1 Yes 2 No		
the Maryland	Direct	10e. Street and Number 2611 RITCH					10f. Zip Code 2074	÷7	1		izen of What Country? UNITED STATES		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland cent of Health and Mental Hygiene.  Int: If item 27 is marked other than "natural", or items 23s or 28s-f she	To Be Completed by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	2 X Married	12. Was Deced Armed Ford 1 Yes If Yes, Give Yeer		If Y	s Decedent of Hisp es, specify Cuban, Yes 2 \tilde{X}\ No	Mexican, Puerto		White, e	American Indian, Black, etc.		
136 hin 72 hours aft e. than "natural"	Completed by	45 Decedentia Educati	ion (Specify only	or Dates: y highest grade College (1-4		16a. Deceden during m	t's Usual Occupationst of working life. I	on (Give kind of v DO NOT use reti		16b. Kind of Busir	ness/Industry		
21215-0036 21216-0036 July be filed within 7 I Mental Hygiene.	Be Comp	17. Father's Name (First	, Middle, Last)	PEOP1	FS	PROJE			e (First, Middle, I	PRIVATE Maiden Surname)  ALSTO			
MD 21; Id 2 should b lith and Men n 27 is marl	To E	19a. Informant's Name/R	OPLES /			2611 I	Address (Street	and Number or F		nber, City or Town,	State, Zip Code) MD 20747		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If iten 27 is marked other ti		20a. Method of Disposition  1 X Burial 2 C  4 Donation 5 0	remation 3	_	n State C	rematory or oth URRECT	ON CEMET	ERY 7/0			MARYLAND		
Balt permit. Depart		21. Signature of Funeral  23a. Party. Enter the dis-	N. (	ornel	uus)	747	74 LANDOV	ER ROAD	, HYATTS	SVILLE, M	HOME, INC. ARYLAND 20785 Approximate Interval		
Physicia /Medica Examine	al .	failure. List only on Immediate Cause (Final or condition resulting in a	e cause on eac disease a]	h line.	nsive A	theros	clerotic		1.5		Between Onset and Death		
	iiner	Sequentially list conditio if any, leading to immedi cause. Enter Underlying	ate Di Cause	ue to (or as a co	onsequence of	):							
50, te be e ecuted ysician and	al Examiner	(Disease or injury that in events resulting in death	n) Last Di	ue to (or as a co									
<b>3760,</b> fic te be extended by sician	n/Medical	IF FEMALE: 23b. Was decedent pregr			tcome of pregn	ancy	me, g929	7-30-12 Ectopic pregna		23d. Date of de	livery Day Year		
Box 68760, e death certific te be the attending hysici	Physician/M	past 12 months?		4 Pregnan	it at time of dea	ath 5 Oth	ner (Specify)			y,			
IS, P.O. Equires that the densigned by the	ā Ā		t conditions o	contributing to d	eath but not re	sulting in the u	nderlying cause giv	ven in Part I.		2 V No 3	te to the cause of death?  Probably 4 Unknown re autopsy findings available		
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending. In the Funeral Director.	Completed								autop perfor 1 <b>V</b> Yes	sy prio med? dea	r to completion of cause of		
f Vital Physician or this cert		25. Was case referred to examiner?  1  Yes 2  27. Manner of Death		spital: 1 Inp		ER/Outpatient 28b. Time of In	3 DOA		g Home 5	Residence 6 (	Other:		
IVISION OF or Attending Pl after death. Director: After	3 3	1 X Natural 5 2 Accident	Pending Investigation	(Month, Da	ay,Year)			es 2 No			or Rural Route Number, City		
Divis Hospital or A 24 hours after Funeral Dire	5	Suicide 6  4 Homicide  29a. Certifier 1 Certi	Could not be determined	(Specify)	of mv knowledg	e, death occurr	red at the time, date	and place, and	or Town, Si	tate)e(s) and manner as	stated.		
To the within 2	Medical	(01.0011 0111)	cal Examiner: 0		examination an			death occurred a		and place, and due			
		30. Name and address of	f person who co	moleted cause	of death (Item)	23a)	O.C.M	l.E.		June 25, 201	2		
Ц	State	Donna M. Vince	nti, MD A	ssistant Me	,	iner 900	W. Baltimore S	Street, Baltim	nore, MD 212	223			
	strar	11111 - 0		Deve	1.	parke							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Alma Pfeltz C. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Good Samaritan Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Hours Min. **Director** 214-24-0173 1 M 2X F 84 24/1927 Marvland or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland **Funeral Director** 1 √ Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6040 Harford Rd. 21214 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 'natural", or Completed by 1 Never Married 2 Married 1 Yes : 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: SpecifyWhite 3√Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry C. Wiles Jennie Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonny O'Neill / Daughter Covington Dr., Shrewsbury, PA 17361 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 5 Other (Specify) Woodlawn Cemetery Baltimore 22. Name and Address of Facility
Parkview Funeral Home & Cremation
7527 Harford Rd, Baltimore, MD 21 Signatur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus, or each line. Interval Between Immediate Cause (Final Heurscher Onset and Death Physician/ ander Vaschlan disease or condition resulting in death) Medical Examiner ear Sequentially list conditions Examine ir any, leading to immediate cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran use as the burial-trar Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnam 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Month signed by the at d be detached for 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? after death.

Director: After this certificate I 1 ☐ Yes 2 ☑ No 1 Yes 25. Was case referred to medical filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No injury Investigation Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completed cause of death (Item 23a) (Type, Print) Hinson , Wd evin 5001 aven 31. Date filed (Month, Day, Year) Registrar's Signatur State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 26 JUNE RHONDA L. PROSSER 2012  $A^{\,\mathsf{M}}$ 2:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS TIMONIUM BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours JAN. 31, 1960 Country) Director 219-82-1125 1 🗆 M 2X 🗆 F 52 MD ortent: If item 27 Is merked other then "netural", or items 23a or 28a-f show Injury or other treumetic event, the Medical Examiner must be routlied at Page 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Health and Mental Hygiene. ent: If item 27 Is merked other then "netural", or items 23a or 28a-f sho 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 TNo BALTIMORE KINGSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11200 LYNN DR 21087 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 200 14. Race - American Indian 1 Yes 2 No Black White etc. Ď 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) BOOKKEEPER PRINTING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ WILLIAM CROUCH MARY RYNARZWSKI 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11200 LYNN DR KINGSVILLE, MD 21087 BARRY PROSSER-HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportent: If ite
eny Injury or ot
once. 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State ST. JOSEPH CEMETERY 6/29/12 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 22. Name and Address of Facility SCHIMONEK FUNERAL HOME 21. Signature of Funeral Service Licensee 9705 BELAIR RD NOTTINGHAM, MD 21236 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, et only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the attending physicien and ched for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Rhonda Prosser Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Day erel Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached t 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 X No 욛 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of co (Month, Day, Year) 08 person who completed cause of death (item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

29

2300 Dala

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 2 2. Date of Death

		-	For State Registrar		Otate of W	iai yiai k			e of De		vicinarity	Reg. N	0.201	2	20792	2
	Physicia	n/	1. Decedent's Name	(First, Middle, La:	st)	· ·					2. Date of De		av . Ye	ar	3. Time of Death	Page 1
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	Funeral		5. Social Security Nur	mber 6. S	ex 7. Ag	je (In yrs. la	st birthday)	If Unde	r 1 Year   I	MILLS f Under 24 Hrs.	8. Date of Bir		9.	Birthpla	ace (State or Foreign	_
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	7		30. Name and address	ss of person who	completed ause of	eath (Item	23a) (Type, P	rint)								-
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Lee Ayler Roper 5201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE AGNES HOSPITAL Months Days Hours Min. July 1947, 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral X** M 2□ F 80 Yrs 215-28-3531 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yes 🙀 No Director Baltimore Halethorpe Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 United States 1006 Downton Road Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygient Important: If item 27 is marked other that any Injury or other traumatic event, the konce. Material Records Department Of Defense 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lila Ayler Wallace Roper 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 Downton Road, Halethorpe, Maryland 21227 Patricia Roper / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery June 29,2012 Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of FacilitAMBROSE FUNERAL HOME, INC. ure of Fureral Service Licenses augo am action Marse 1328 Sulphur Spring Rd., Arbutus, Maryland 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed and burial-trai Due to (or as a consequence of): ROPER LEE Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No ģ Day 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 ☐ Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 √ Inknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death 1 2 Yes 2 □ No 24a. Was an has page 2 autopsy erformed certificate 2□No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA P After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30802 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 900 CATON AVE BALTIMORE, MD21229 State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **Gail Crumity Robinson** JUNE 6:05 PM 201 Medical Eacility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min 1 M 2 X Director 063-42-3592 61 NY Feb 4, 1951 Usual Residence of Dece Schou 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 No **Baltimore** MD **Baltimore** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3849 McDowell Lane 21227 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Force Black, White, etc. ō þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Black "natural", Specify: Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the **Burger King** Manager 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Inez Crumity Walter Crumity 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is a any injury or other traumonce. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3849 McDowell Lane Baltimore, MD 21227 **Lamont Crumity** Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Rem cemetery, crematory or other place, I from State Jun 27, 2012 Catonsville, Maryland Metro Crematory, Inc. 4 ☐ Ponation 5 ☐ Other (Specify) unera 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final and Death Physician/ day disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events southing in death), act. Examine Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ ¥es 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death.

1 Yes 2 No 24a. Was an page 2 has autopsy performed? 25. Was case referred to medica funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at (Month, Day, 1 🗹 Natural 5 Pending work? 2 🗌 No Accident Investigation completely filled in by the Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) JUNE 20, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

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32. Registrar's

2012

STAGUESHOSP. BALTIMERE, ND 21229

# ERVIN G Ray has $45e^{-\Gamma}$ $E^{RV}$ Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Print in	Black Ir	ndelible Ink	k. Ensure	All Copie	es Are L	_egible.	
		State of Marylan				Mental Hy	ygiene	0010	00701
		Registrar	Cer	tificate of <i>E</i>	<i>Death</i>	1.00 (0	Reg. No.	2012	20/9
Physicia	n/	1. Decedent's Name (First, Middle, Last)  Ervin G.	Do.,	hauser		2. Date of D Month	Day	Year	3. Time of Death 245 A M
Medic		Ervin G.  4a. Facility Name (if not institution, give street and number)	nau	4b. City, Town, or	Location of Dos	6 ath		ounty of Death	213/11
Examin	er	FRANKLIN SQUARE HOSPITCH	l		US ed C			Balti	MORP
Funeral	2	5. Social Security Number 6. Sex 7. Age (In yrs. I			If Under 24 Hr	s. 8. Date of B	irth		place (State or Foreign
Director		088-14-9430 1XIM 2□F 89	Yrs.	Months Days	Hours Mir	, ,	, ,	Coun	**
, MC		Usual Residence of Decedent				reb.	26,192		York
yland -f sh ed at	Director		ty, Town or Lo					]1	0d. Inside City Limits  1 ☐ Yes 2X No
e Mai r 28a notifi	Oire	MD Baltimore	E	dgemere  10f. Zip Code			40. 077		
iffh th	ral	9108 Avenue A		101. Zip 00de	2121	9		n of What Cour ited St	•
ath w	Funeral	11. Marital Status 12. Was Decedent Ever in U.3	S. 13. V	Was Decedent of Hi				Race - Americ	
or its	by F	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ▼ Yes 2 ☐ No	1	f Yes, specify Cuba	n, Mexican, Pue	rto Rican, etc.)		Black, White,	
ırs aft ıral", I Exa		3 ★ Widowed 4 Divorced If Yes, Give Year or Dates.		I ☐ Yes 2 🛣No	Specify:		Spi	ecify: W	hite
2 hou "natu edica	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	dent's Usual Occupa	ation Juring most of w	orking	1	of Business/Inc	-
thin 7.	No.	Elementary/Secondary (0-12) College (1-4 or 5+)	life. D	O NOT use retired)		ŭ.	Gene	eral El	
ed wit Hygie other	o l	12 Years 17. Father's Name (First, Middle, Last)	Pro	duction C		ame (First, Middle	Maiden Sur	Compan	У
be fill ental rked (	10	Mervin Rauhauser				lara Arr		ria rio)	
hould and M s mal		19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or F	Rural Route Numb	er, City or To	wn, State, Zip C	Code)
id 2 si salth a n 27 i		Jeffrey Rauhauser ( son )	81.	5 South H	lo1mes S	treet S	Scotia,	NY 1	2302
of He of He fiten roth	4			sition (Name of natory or other plac	e)	Date	20c. Loca	ition - City or To	wn, State
Page ment tant:			ory Ga		7/2	/2012	Color	nie, NY	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22 <b>I</b>	R. Name and Addres Duda-Ruck 7922 Wise	s of Facility <b>Funera</b>	1 Home o	f Dund	lalk, Ir	nc.
<u> </u>	_	23a. Part 1. Enter the disease, or complications that caused the deat						and 212	
		shock, or heart failure. List only one cause on each line.				to or respiratory t	arroot,		Approximate Interval Between Onset and Death
Phylician Medical	8 1	Immediate Cause (Final disease or condition resulting in death)  a. Multi- C  Due to (or as a consequence)	orga	n rail	ure			_	
Examiner		See as a solisection of the second se	dence						
	ner	Sequentially list conditions, if any, leading to minimize the sequence of the	uence of):						
ecuted and I-transit	xaminer	cause. Enter Underlying Cause (Disease or injury that initiated events  c							
exectian ar	ш	resulting in death) Last Due to (or as a consequence of the control of the contro	uence of):						
ate be hysic the bi	Physician/Medical	d							
ertifica ding p	/Me	IF FEMALE: 23c. If yes, outcome of pregnant 23c. If yes, outcome of pregnant	ancy						
ath ce attend for us	cian	in the past 12 months?	aldeath 3	Ectopic pregnanc Other (specify)	у		230	<ul> <li>Date of deliver</li> <li>Month</li> </ul>	ery Day Year
he de y the ached	hysi	1   Yes 2   No 4   Pregnant at time of 6 9   Unknown							
that t ned b e deta	by P	Part II. Other significant conditions contributing to death but not res	sulting in the u	inderlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to th	e cause of death?
uld b	ed k					. 1 🗆	Yes 2	No 3 🗆 Prob	pably 4 Unknown
iw rec as bee 2 sho	plet					24a. Wa	s an 2	24b. Were autop	osy findings available
The la	Completed					per	formed?	death?	mpletion of cause of
cian: ertific ector,	Be	25. Was case referred to medical examiner? [Hospital:			ace of Death (Ch	eck only one)			
Physician: The lav this certificate has	<u>1</u>	1 Ves 2 No Hospital: 1 Inpatient 2 27. Manner of Death 28a. Date of injury	ER/Outpatier		4 ☐ Nursing	Home 5 Res			)
ding I th. After funer	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year)	injury	work		. 28d. Describe	how injury or	ccurred	
Atten r deal cctor: by the	rtifi	3 Suicide 6 Could not be			100 2 1110	28f. Location	(Street and N	 Iumber or Rural	Route Number,
al or safte		building, etc. (Specify	y)				wn, State)		
To the Hospital or Attending Physician: The law requires that the death certificate be exewithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial-	Medical	29a. Certifier 1 Certifying Physician: To the best of my know (Cirect 2 Medical Examiner: On the basis of examinatio							
the Libin 24	Me	only one) 3 Certifying Nurse Practitioner: To the best of r		, death occurred at the	ne time, date and		the cause(s)	and manner as s	tated.
5 Wit		29b. Signature and title of certifier		29c, License				signed (Month, I	Day, Year)
Nan		30. Name and address of person who completed cause of death (Item	n 22a) /Ti T		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		6		20.2
120		DR Richard Lai 9000 F	RANK	Lin Sau	lare	UR Ba	Ltow	nd Zi	237
Stat		31. Date filed (Month, Day, Year) 32. Registrars Signa	barrel			, , , , , , , , , , , , , , , , , , ,			
Registra	ar	JUN 29 2012 Denun B. 19							

State Registrar

DHMH 17 Rev 06-2011

12-04799 Chadd Martin Rygiel

Please	ype or Print in Black Indelible Ink. Ensure All Copies Are Legib	ıe.
	State of Maryland / Department of Health and Mental Hygiene	

madu Martin N	_	1- For State Registrar	tate of Marylan		ficate of De			2 U eg. No.	12 20/9
Physicia	an/	Decedent's Name (First, Midd	dle,Last)				2. Date of Dea	ith	3. Time of Death
Medical Exami	ner	Chadd MARTIN					June 26, 2		1418 hrs
		4a. Facility Name (if not institution 13 Gunview Farm Co		er)		ity, Town, or Location of erry Hall	of Death	4c. County of Dea Baltimore Co	
Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last				rth (MM/DD/YYYY) 9. B	
Director		218-92-1920	1XM 2F	33	Yrs.	Ionths Days Hours	3-6-1	979 Fore	ountry) MARYLAN
<b>b</b>		Usual Residence of Decedent 10a. State 10b. County		Inc. City To	own or Location				10d, Inside City Limits
ow any			LTO.	Toc. City, To		RY HALL			1 Yes 2 No
faryland	횼	10e. Street and Number				f. Zip Code	14	0g. Citizen of What Co	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Director	13 GUNVIEW FA	PM COUPT			21128		USA	<b>,</b> ·
with th		11. Marital Status	12. Was Decede			cedent of Hispanic Ori	gin? ( Specify Yes or No	)- 14. Race - Ame	erican Indian, Black,
death or iten	Funeral	1 Never Married 2 N	1 Yes	2 X No		pecify Cuban, Mexican		White, etc.	
after	þ		vorced If Yes, Give Year or Dates:			2 X No specify:		Specify:WHI!	
hours		15. Decedent's Education (Spe Elementary/Secondary (0-12)				sual Occupation (Give f working life. DO NOT		16b, Kind of Business	s/industry
136 thin 72 house. then "nasedical Exa	ompleted	12TH	, Joneyo (. , ,	5.5.7	TECI	HNICIAN		INSURANCE	E
5-0036 led within Hygiene. other tha	S	17. Father's Name (First, Middle	e, Last)				's Name (First, Middle, I	Maiden Surname)	
be fi	a	RICHARD JOHN R					CE MARTIN		
- 2 2 3 ±	٩	19a. Informant's Name/Relations				•		mber, City or Town, Sta RY HALL。 MI	
	H	JOYCE CLAY  20a. Method of Disposition		OTHER 20b. Pla		NVIEW FARM (Name of cemetery,	Date Date	20c. Location - City of	
		1 Burial 2 Crematio		State	matory or other p	•	7-3-2012	CLEN DID	NITE MD
Baltimore permit. Pages I Department of P Important: If injury or other	ŀ	4 Donation 5 Other S 21. Signature of Funeral Service	Specify:	AIL		REMATORY and Address of Facility		GLEN BURI	
Depi Depi		Stefance o'	Rinek	~		BELAIR ROA		HAM, MD. 2	
Physician		23a. Part I. Enter the disease, or failure. List only one cause	r complications that cause on each line	ed the death. Do	o not enter the m	ode of dying, such as o	ardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease		ntoxicat	tion and	Cocaine U	se		Death
and the same of th		or condition resulting in death)	Due to (or as a co	nsequence of):					
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	nsequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a co						
ited d ansit	Exa	events resulting in death) Last	d.	risequence or).					
OX 68760, ath certificate be executed attending physician and or use as the burial - transit	dical	UNPENDED	AMENDED23	a,27,28a	a-f,per	me,g929 7-	2-12 sm		
760, icate be physici the buri	/Me	IF FEMALE: 23b. Was decedent pregnant in t		come of pregnar				23d. Date of delive	
certification	cian	past 12 months?	I LIVE DILLI	i at time of death	2 Fetal do	eath 3 <u></u> Ectopi₁ (S <i>pecify</i> )	c pregnancy	Month	Day Year
Box 687: death certific the attending p of for use as th	Physician/	1 Yes 2 No 9 Un	nknown g Unknown	1	O O O O	(0,000.1))			
that the d	by P	Part II. Other significant condi	tions contributing to de	eath but not resu	ılting in the under	lying cause given in Pa		obacco use contribute t	
ords, P w requires the as been signe should be d	9	J				<del></del>	1 Yes		
ord aw req as bee	plet						autop		autopsy findings available completion of cause of
Rec The l	Completed						1 <b>✓</b> Yes	2 No 1 🗸	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that it is after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be deated.	B	25. Was case referred to medica examiner?	Hospital:	atient 2 EF	R/Outpatient 3	26.Place of Death  DOA  Other	·	Residence 6 🗸 Oth	ar Scane
n of Viding Physi  After this funeral dir	리	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury 28	Bb. Time of Injury			how injury occurred	el. Scelle
ion C tending eath. tor: Aft the fun	ᇋ	1 Natural 5 Pen	(Month, Da	ıy,Year)	Ed 14:12	1 Yes 2 X	N∘ unknown	1	
Vision Attender in by t	fica	= -	28e. Place o	f Injury - At home	e, farm, street, fa	ctory, office building, et	tc. 28f. Location (		Rural Route Number, City
Divisipital or At ours after deral Directification by	Certification:	4 Homicide dete	ermined (Specify)	Single I	Family H	lome	Perry H	State) 13 Gunvi Hall, MD.	ew farm Ct.
Hos Fun tely			Physician: To the best of aminer:On the basis of e						
To the within 2 To the complet	Medical	29b. Signature and title of certifi	and manner state			29c. License number		29d. Date signed (M	
		Canol	Hella	·v		O.C.M.E.	•	June 27, 2012	
_ A		30. Name and address of person	n who completed cause of	of death (Item 23	3a)				
φ		Carol H. Allan, MD	Assistant Medical	Examiner	900 W. Balt	imore Street, Balt	imore, MD 21223		
St Regist	ate	31. Date filed (Month, Day Year)	32. Regis	strar's Signature	ale				
DHMH 17 Rev 1/2		W A 1015	,	1	ORIGINAL				
COME COOC	J- 1		OCME	,	CRIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

Patient Knowa as Michael Andrew Lawpson
Baltimore, Maryland 21215-0036 本文を上下る。 から Mを Division of Vital Records, P.O. Box 68760 名

		AMEND #25, PER ME	199e or Prii 6929, 7/17	12 TF	I <b>ack</b> In	idelibi idmon	e ink tof ⊔	Lealth	and M	II Copie	s Are	Legi	ble.	0 -
	•	_ State	State of Ma	ai yiai iu		tificate			anu ivi	ена пу	_	20	12	2079
		Registrar  1. Decedent's Name (First, Middle, La	st)		Och	incate	OID	Calli	Т	2. Date of De	Reg. No.			3. Time of Death
Physicia: Medic		Michael Andr	ew Samps	on, S	Sr.					June	Day 2 (a)		Year 2/2	521 pm
Examine		4a. Facility Name (if not institution, give	e street and number)	Balti	nicpe	4b. City, 1		Location of		City		County o		
Funeral		Social Security Number     6. S		(In yrs. last	birthday)	If Under Months	1 Year Days	Jf Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			9. Birthplac	ce (State or Foreign
Director		219-88-2024 1 Usual Residence of Decedent	1 🛛 M 2 □ F	48	Yrs.	ontino	Sayo	1.00.0	1 1	01 02	-	4	Gournay)	MD
show	0	10a. State 10b. County		10c. City, 7	Town or Loc	ation				*****			10d	. Inside City Limits
Marylt 28a-f	rec	MD NA		Ва	altim	ore								1 🛱 Yes 2 🗆 No
th the Maryland as or 28a-f show the rediffed at	a	10e. Street and Number				10f. Zip					10g. Citiz		hat Country	?
death with the Maryland items 23a or 28a-f sho ner must be notified at	Funeral Director	3910 West Cold						215				U.S	5.A.	
or ite	년 고	11. Marital Status 1   Never Married 2   Married	12. Was Decedent E		13. W	/as Decede Yes, speci	ent of His fy Cubar	spanic On n, Mexicar	gin? (Spec 1, Puerto F	cify Yes or No- Rican, etc.)	1		<ul> <li>American</li> <li>White, etc.</li> </ul>	
rs afte	ed b	3 Widowed 4 Divorced	1 Yes 2 Y If Yes, Give Year or Dates.	••	1	☐ Yes 2	No 🔀 No	Specify:	:		5	Specify:	Blac	k
be filed within 72 hours after ental Hygiene. ked other than "natural", or ic event, the Medical Exemi	Completed	15. Decedent's E (Specify only highest gr			16a. Decede	ent's Usual	Occupa	tion	t of workin	na	16b. Kir	nd of Bus	siness/Indus	stry
thin 7	팃	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	life. DC	NOT use	retired)	9		.5	501	f Fr	nploy	ro-d
Hygir Other ent,	a l	11th grade  17. Father's Name (First, Middle, Last)	na		пс	ome I	I din .			(First, Middle,			пртоў	eu
t be fi dental rked tic ev	욘	Eddie Madison					1			Sampso		amamoj		
should be filed within 7: n and Mental Hygiene. 7 is marked other than raumatic event, the Me		19a. Informant's Name/Relationship (1	Type, Print)		19b. Mailing	g Address	(Street a	nd Numbe	er or Rural	Route Number	er, City or 1	Town, Sta	ate, Zip Cod	(e) 21215
and 2 : Health em 27 ther tr		Dawnet Taylor-S	Sister					ld S	Spri	ng La	ne,	Balt	rimor	e, Md
nit. Page 1 and 2 should be filed within 72 } artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "I injury or other traumatic event, The Med 8.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State		ce of Dispos netery, crem			)	D	ate			City or Town	
nit. Pa artme ortani injury		4 Donation 5 Other (Speci 21. Signature of Funeral Service Licen			On-S	Name and	A ddroos		/2/2	012	Ba	ltir	more,	Md
permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra		Dunis	BKe	Ke	I Ma	ırch	F/H	Wes	st	Balt	imor	0 - 1	MA 21	.215
		23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	plications that caused	the death. I	Do not enter	the mode	of dying	, such as	cardiac or	respiratory ar	rest,	<u>C/</u>	A	pproximate
Physician/		Immediate Cause (Final disease or condition	Colo	nic	Per	-PB1	at	700	1					terval Between nset and Death
, Medical Examiner		resulting in death)	Due to (or as a	consequen	ice of):							1/	/	
	<u>ē</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	consequen	ice off.		_		-	10/	1.4	EXAMIN	VER	
ted J ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 10 (01 03 0	oonsequen	00 01).					AT ON APPROVE	D BY WEDIC	AL EXAMINA		
be executed sician and burlal-transit	Ë	that initiated events resulting in death) Last	Due to (or as a	consequen	ce of):			•	CERTIFIC	CKION PL				
ate be	dical	•	d						_	1				
ertifica ding p	Š	IF FEMALE:	23c. If yes, outcome of	of pregnance	v									
atten atten i for u	ciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 Live Birth 2 4 Pregnant at	☐ Fetal d	eath 3 🔲	Ectopic pr		,			2	3d. Date! Mont	of delivery th Da	y Year
the de by the tachec	ş	9 🗌 Unknown	g 🗌 Unknown											
s that gned be de	Completed by Physician/Medi	Part II. Other significant conditions of Costroclu	ontributing to death bu	t not resulti	ing in the un	derlying ca	ause give	en in Part I	1.					ause of death?
equire	eted	C (0211.00	zm aifi	1100			4			1 📙	Yes 2la	No 3	Probab	ly 4 🗆 Unknown
has b	g G									24a. Was auto		pri		findings available letion of cause of
ifficate tor, pa	o l	25. Was case referred to medical					26 Pla	co of Dead	th (Check	1 🗌 Yes	2 No		Yes 2	No
ysicia is cert direct	<u>ම</u>	examiner?	Hospital:	nt 2 🗆 ER	VOutpatient	3 🗆 DO	Other	~		ne 5 🗆 Resi	dence 6	Other	(Specify)	
frer th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,	/ 28	b. Time of injury		c. Injury work?	at		8d. Describe I				-
death death stor: A y the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	oe ·			М		/es 2 □	-		_			
		4 Homicide determined	28e. Place of Injur building, etc.		e, tarm, st <i>r</i> e	et, factory,	office		2	8f. Location (S City or Tov		Number	or Rural Ro	ute Number,
ospita hours unera	Medical	29a. Certifier 1 Certifying Phy	vsician: To the best of n	ny knowled	ge, death o	ccurred at 1	the time,	date and	place, and	d due to the c	ause(s) and	d manner	r as stated.	
the H hin 24 the F		only one) 3 L Certifying Nur	iner: On the basis of ex- se Practitioner: To the	amination ar best of my l	knowledge, o	death occur	red at the	i, death oc e time, dat	ccurred at t te and plac	the time, date a be, and due to	and place, a the cause(s	and due t s) and ma	o the cause( nner as state	(s) and manner stated ed.
\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	- 1	29b. Signature and title of certifier  Belaude	Guers				License		000				Month, Day,	
	ł	30. Name and address of person who			Sa) (Tuno P		0				Ju	1102	6,2	012
り		GERARDO (	G GUECE	W	1D	CINA	HO!	SPITI	14 6	DF BF	ALTIN	NOR	E	
State	-	31. Date filed (Month, Day, Year)	32. Registrar	<u> </u>							-			
Registra		JUN 29 2012 /2	seve B.	May	Car									

DHMH 17 Rev 06-2011

Delvoy Sun 12-04652 Unk-Unk	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene	0070
CHA-CHA	1- For State Certificate of Death	2079
Physician/	7 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3.	Time of Death
Medical Examine	Delroy Summers June 20, 2012  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	1454 1115
	4303 York Rd. Apt. 3 Baltimore NA	
Funeral Director	5. Social Security Number  3. Head 3035  1. Mage (In yrs. last birthday)  5. Social Security Number  3. Hours   If Under 1 Year   If Under 24Hrs.    4. Days   Hours   Min.    5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24Hrs.    5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthperior    5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthperior    6. Sex   7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthperior    6. Sex   7. Age (In yrs. last birthday)   Yrs.   If Under 1 Year   If Under 24Hrs.    8. Date of Birth(MM/DD/YYYY)   9. Birthperior    6. Sex   7. Age (In yrs. last birthday)   Yrs.   If Under 1 Year   If Under 24Hrs.    8. Date of Birth(MM/DD/YYYY)   9. Birthperior    6. Sex   7. Age (In yrs. last birthday)   Yrs.   If Under 1 Year   If Under 24Hrs.    8. Date of Birth(MM/DD/YYYY)   9. Birthperior    8. Date of Birth(MM/DD/YYYY)   9. Birthperior    9. Birthperior   Yrs.   If Under 24Hrs.    9. Date of Birth(MM/DD/YYYY)   9. Birthperior    9. Birthperior   Yrs.   If Under 1 Year   If Under 24Hrs.    9. Date of Birth(MM/DD/YYYY)   9. Birthperior    9. Birthperior   Yrs.   If Under 24Hrs.    9. Date of Birth(MM/DD/YYYY)   9. Birthperior    1. Date of Birth(MM/DD/YYYY)   9. Birthp	try) MD
p on an	10a. State 10b. County 10c. City, Town or Location 10	Od. Inside City Limits  Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	10e. Street and Number  10f. Zip Code  10g. Citizen of What Country  4330 York Rd  USA	a
or items 23a Funest be not	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American White, etc.	n Indian, Black,
s after deat tral", or its niner must	3 Wildowed 4 Divorced in less sive feat in less 22 to specify.	ζ
5-0036 ed within 72 hours tygiene. other than "natur the Medical Exam Completed 1	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	ustry
21215-0036 uld be filed within 7 Mental Hygiene, marked other than e event, the Medica	17, Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
215- be filed thed off ent, the		
D 21; should the should the string marker of the st		ip Code)
e, MD   and 2 sho Health and item 27 is	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or To	wn, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1 Burial 2 Cremation 3 Removal from State Crematory or other place) 4 Donation 5 Other Specific Metro Crematory 6-39-12 Catorsville in	no _
Balti Permit. Departn Import	21. Signature of Funeral Service Cyclensee  22. Name and A dress of Facility  San P. March FH 2 70 Fredhilton Pass Basto. r	MD 21:239
Physician	23a. Part Untertitle disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Myocardial Fibrosis  Due to (or as a consequence of):	Death
	Sequentially list conditions,	
amine	cause. Enter Underlying Cause (Uisease or injury that initiated  Due to (or as a consequence of):	
	d d	
0, 0, se be exe vsician : burial -	IF FEMALE:    AMENDED   23a,27 per me g930 8-20-12 vt 4a   23d. Date of delivery   23d. Date of delive	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transifiedical Certification: To Be Completed by Physician/Medical Exhedical Certification:	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day  1 Yes 2 No 9 Unknown 9 Unknown	y Year
P.O. B s that the d med by the detached is detached by		
ds, Frequires requires sign outld be ented the	24a. Was an 24b. Were auto	osy findings available
Division of Vital Records, P.O. Box tal or Attending Physician: The law requires that the death ra after death.  al Director: After this certificate has been signed by the attered in by the funeral director, page 2 should be detached for untilication: To Be Completed by Physic	autopsy prior to comperformed?   1 ✓ Yes 2 No 1 ✓ Yes	2 No
Vital yysician: this certi director	25. Was case reterred to medical  examiner?  Hospital:   Input   Description   Descrip	cene
on of \\ nding Phy tth. r: After tt re funeral t	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how injury occurred	
Division o spital or Attending spital or death. neral Director: Aft filled in by the fune Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural or Town, State)	Route Number, City
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificantletely filled in by the funeral director, Medical Certification: To Be (		:ause(s)
To with the last of the last o	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month)  O.C.M.E.  June 21, 2012	, Day, Year)
1. Obend	30. Name and address of person who completed cause of death (Item 23a)	
1 1	Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registra	e 31 Date filed 90 2012. Year June 32. Reflistrars forest	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year Month Physician/ Ronald Scall 930 AM 200 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Randallstown Baltimore Gensis Healthcare-Randallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Numbe 6. Sex 1 X M 2 C 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 7-971-1949 ar MD Director 62 216-54-1773 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Windsor Mill MD Baltimore 1 Tes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21244 IISA 3241 N. Rolling Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Deceue... \_ Armed Forces? 1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-American 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 X Divorced ear or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 9th College (1-4 or 5+) Labor Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Clifford Scaff Shirley O. Price 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Verna L. Squirrel/Sister
20a. Method of Disposition Rolling Rd., Windsor Mill. MD 21244 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-27-2012 Metro Cranatory Baltimore, MD 22. Name and Address of Facility Lie Funeral Home P.A. of Baltimore Co. Signature of Funeral Service Lize 9200 Liberty Rd., Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Advanc disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner June Sequentially list conditions Examiner cause. Enter Underlying physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy certificate hai performe 1 ☐ Yes 2 ☐ No 1 Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 40 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? iniury 5 Pending 2 🗆 No 2 Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical CE Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

2

only one) 29b. Signature and title of certifie

SADIA

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

1210

LIbert

9109

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BADA

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Road

D0072109

RandallStown

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	Oldio or Marylan	Ce	ertificat			10 1110	incan i iy	Reg. No.	201	2	20800
	Physicia	m/	1. Decedent's Name (First, Middle, Last)						2	. Date of Dea	_	/ Ye	ar	3. Time of Death
	Medic	al	Poonsawat Suthipa							June	25			12:55 P <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give s	treet and number)				Location of [	Death			County of I		
ممحبرره	Funeval		Casey House  5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthdav		ockvi	If Under 24	Hrs. 8	. Date of Birt	_	Montg		Ly lace (State or Foreign
	Funeral Director			] M 2 🖾 F	Yrs.	Months	Days	Hours	Min.	(Month, Day	y, Year)		Count	ry)
	MO.		Usual Residence of Decedent	101		Ц	لــــا			Jan 22	2, 19	ני   110	Thailand	
	yland -f shc ed et	호	10a. State 10b. County	10c. City	, Town or L								10	Od. Inside City Limits
	e Mar r 28a- notifi	Ë	MD Montgoms  10e. Street and Number	ery			ver S	Spring			10 00			1 Yes 2 K No
	ith th	ral				101. 21		001				izen of Wha		try?
	be filed within 72 hours after death with the Maryland antal at yegiene. Ked other than "natural", or items 23a or 28a-f show to event, the Medical Examiner must be notified at.	Funeral Director	1000 Baleview Driv	VE 12. Was Decedent Ever in U.S	i. 13	. Was Dece	209 dent of His		n? (Specif	y Yes or No-		ailan 14. Race -		an Indian.
۵	or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔯 No					Puerto Rid	y Yes or No- can, etc.)		Black, V		
Maryland 21215-0036	ırs aft ural'',		3 X Widowed 4 Divorced	If Yes, Give Year or Dates.		1 🗌 Yes	2 LX-No	Specify:				Specify:	As	ian
<u>,</u>	"nat	ple	15. Decedent's Edu (Specify only highest grad		(Giv		rk done d	ition uring most o	f working		16b. Ki	ind of Busin	ess/Ind	ustry
2	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+) 2	life. Teac	DO NOT us	e retired)				ᄗ	ucati	on	
D N	iled wit I Hygie other ent, it	as l	17. Father's Name (First, Middle, Last)		Teac	iler_		18. Mother's	's Name (F	First, Middle,			011	
an	ould be fil nd Mental marked matic ev	၉	(unk)			( u	nk)	(unk		,		,		(unk)
a <sub>Z</sub>	should and Me is mar raumati		19a. Informant's Name/Relationship (Typ	e, Print)	19b. Ma			nd Number o	or Rural R	oute Numbe	r, City or	Town, State	e, Zip C	ode)
	□ ± 6 t		Bhanit Yantaprase	rt / Niece	111	101 Ge	orgia	a Ave	#641	Wheat	on,	MD 20	902	
ore	~ O == ==		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ I		lace of Dispernetery, cr	position (Na ematory or	me of other place	e)	Dat	te	20c. Lo	ocation - Cit	y or To	wn, State
Ĕ	mit. Page partment o cortant: If		4 Donation 5 Other (Specify)		. Jour	ney C	remat	ory 6	/28/	2012	Woo	dbine	, Ma	aryland
Baltimore,	permit Depart Impor any in		21. Signature of Funeral Service Lifense	e Roste MOI	251 E	22 Name a 501ng Beverl	Homes V L.	saffacility Crema Heckr	tion	Servi P.A.	ce P Cla	.O. B rksvi	ox 11e	784 , MD 21029
			23a. Part 1. Enter the disease, or compleshock, or heart failure. List only one	lications that caused the death										Approximate Interval Between
~ F	nysician/		Immediate Cause (Final disease or condition	Dementia									1	Onset and Death
	Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):								1	
	LXammer	<u>.</u>	Sequentially list conditions,	b									$\perp$	
ζ.	sit sit	ii.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or mijury	Due to (or as a consequ	ience of):									
n.	and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequ	ence of):								+	
0	ificate be executed g physician and as the burial-transit	Medical		d										
8760	ficate g phy as the	Med	IS SEMALE.										101	
<u></u>	death certi ne attendin ed for use		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnal 1  Live Birth 2  Feta		Ectopic	pregnanc	v				23d. Date o		
		Physician/I	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of d g ☐ Unknown		Other (s	pecify)					Month		Day Year
P. 0.	law requires that the nas been signed by the e 2 should be detach	by P	Part II. Other significant conditions con	ntributing to death but not res	ulting in the	e underlying	cause giv	en in Part I.		23e. Did to	obacco u	ise contribu	te to th	e cause of death?
ś.	n sign	be d b								1 🗆	Yes 2	131 No 3 l	☐ Prob	ably 4 D Unknown
0.0	w req	plet								24a. Was				sy findings available npletion of cause of
9 9	The law ate has be	Completed			-					autor perfo	rmed?	dea	th?	2 No
g	sian: ] ertifica ctor, I	Be	25. Was case referred to medical examiner?				26. Pla	ce of Death	(Check o	•		1		
5	hysic this co	မ	I LI Yes 2 IZI NO	lospital:				4 ☐ Nurs		e 5 🗆 Resid			Specify)	Hospice
2	Attending Physician: The la is death. ector: After this certificate ha by the funeral director, page	Certificate:	27. Manner of Death  1 X Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time injury	′ l	28c. Injury work	?		d. Describe h	now injury	y occurred		·
Sio	death death ctor: y the	턡	2 Accident Investigation 3 Suicide 6 Could not be		me farm s	M street factor		Yes 2□N	_	of Location (5	Street and	d Number o	r Rural	Route Number,
Division of Vital Records,	ital or A irs after al Dire		4 Homicide determined	building, etc. (Specify			,,			City or Tov	vn, State)	, , , , , , , , , , , , , , , , , , , ,	- riorar	ricato rambo,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu	Medical	(Check 2 Medical Examin	ician: To the best of my knowler: On the basis of examination er: To the best of n	and/or inv	estigation, in	my opinio	n, death occi	urred at th	e time, date a	and place	, and due to	the cau	se(s) and manner stated.
	vithi Song Eog		29b. Signature and title of certifier	N= 1		1	c. License				29d. Dat	te signed (N	lonth, E	Day, Year)
			XEbrah 1	hular, CF	2NP		R14	320	> 1		6	.26	. /	2
	\		30. Name and address of person who co											
	,		Debrah Miller 600 31. Date filed (Month, Day, Year)	01 Muncaster M 32 Registrar's Signat	ill F	Rd. Ro	ckvi l	le, M	D 208	355				
	Sta Registr		JUN 29 201	2 Armer & Signal	1. 6	aves								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Mary				nd Mental H	ygiene	
_			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eatn	2. Date of D	Reg. No.	3. Time of Death
н	Physicia		Yvonne Ruth Smith					June		2012 12:23 A M
-	Medic Examin		4a. Facility Name (if not institution, give stree	t and number)		4b. City, Town, or	Location of	Death	4c. County	
,			15610 Santini Road			Burtons				gomery
	Funeral Director		5. Social Security Number 6. Sex 113–34–0145 1 □ N	7. Age (In )	rs. last birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of E Min. (Month, L		Birthplace (State or Foreign Country)
			Usual Residence of Decedent		9 Yrs.			Oct 2	9, 1942	New York
	yland -f sho ed at	ctor	10a. State 10b. County		. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	r 28a notifi	Director	MD Montgomer  10e. Street and Number	У		Burtons'	ville		10g. Citizen of V	
	with the 23a c		15610 Santini Road				0866			d States
	items			Was Decedent Ever in Armed Forces?	n U.S. 13. V		spanic Origin	n? (Specify Yes or No Puerto Rican, etc.)		e - American Indian, k, White, etc.
36	within 72 hours after death with the Maryland jiene. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		☐ Yes 2 🌠 No		,	Specify:	
00-	hours hatura ical E	Completed	15. Decedent's Educa			lent's Usual Occup			16b. Kind of Bu	usiness/Industry
215	in 72 e. nan "r	dwo	(Specify only highest grade of Elementary/Secondary (0-12)	ompleted) College (1-4 or 5+)	life. De	kind of work done a O NOT use retired)		of working	- 111	G 1 1
121	iled within 73 I Hygiene. other than rent, the Me	ادها	17. Father's Name (First, Middle, Last)	5+	Phys	ical Ther		r's Name (First, Middl		School
Maryland 21215-0036	1 and 2 should be filed v f Health and Mental Hyg item 27 is marked othe other traumatic event,	70 E	Eric Tiderman					Hauser	e, Maiden Surname	
ary	should and M is mar aumat		19a. Informant's Name/Relationship (Type,	Print)	19b. Mailir	ng Address (Street a	and Number	or Rural Route Numi	ber, City or Town, S	itate, Zip Code)
Σ	1 and 2 s of Health item 27 i		Donald Smith / Hus				Rd. I	Burtonsvil		
lore	ge 1 and the street or out		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □ Rer	noval from State		natory or other plac		Date		City or Town, State
altimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature Funeral Service Licen			ey Cremat		6/29/2012		oine, Maryland
Ba	Depar Impor any ir		> Durulax 4	achroff,	Gi MO1251   Be	oing Home everly L.	Crema	ation Serv rotte, P. <i>R</i>	A. Clarks	Box 784 ville, MD 21029
П	-		23a. Part 1. Enter the disease or complical shock, or heart failure. List only one care	ions that caused the						Approximate Interval Between
	Ph_sician/		Immediate Cause (Final disease or condition resulting in death)	Metastat		t Cancer				Onset and Death Years
	Medical Examiner		resulting in death)	Due to (or as a con	isequence of):					
		iner	Sequentially list conditions, if any, leading to immediate cause Eliter Underlying	Due to (or as a cor	nsequence of):					
3	cuted	Examiner	Cause (Disease or injury that initiated events c	Due to (or as a cor					·	
$\tilde{\mathfrak{I}}_b$	death certificate be executed he attending physician and red for use as the burial-transit	dical E	resulting in death) Last	Due to (or as a cor	isequence oi).					
120	icate l g phys	1edic	d. ,							
Box 687	ending r use a	an/N	Zob. Was decedent pregnant	If yes, outcome of pr		☐ Ectopic pregnanc	·y			te of delivery
	ss that the death certifics igned by the attending p be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🎛 No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death 5	Other (specify)			- Mc	nth Day Year
P.O.	The law requires that the ate has been signed by the page 2 should be detach	y Ph	Part II. Other significant conditions contri	outing to death but no	ot resulting in the u	ınderlying cause giv	en in Part I.	23e. Dio	tobacco use cont	ribute to the cause of death?
	uires t n sign uld be	ed by						1 [	Yes 2 X No	3 Probably 4 Unknown
Sorc	law require has been sige 2 should I	Completed						24a. Wa	topsy	Were autopsy findings available prior to completion of cause of
Re	The lar	Con								death? 1  Yes 2 No
ital	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No	oital;		Oth	ar:	(Check only one)		
of V	Attending Physician: ar death. sctor: After this certific by the funeral director,	e: To	27. Manner of Death	28a. Date of injury	2 ER/Outpatier 28b. Time of	28c. Injur	4	rsing Home 5 🔀 Re 28d. Describ	e how injury occurr	
on	ending l sath. or: After the funer	ficat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day, Yea	ar) injury	M 1 🗆	Yes 2 1	No		
Division of Vital Records,	l or Attendater deat Director:	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (Sp	At home, farm, str pecify)	eet, factory, office			(Street and Numb own, State)	er or Rural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	ical	29a. Certifier 1 X Certifying Physicia	n: To the best of my k	nowledge, death	occurred at the time	e, date and p	place, and due to the	cause(s) and manr	ner as stated.
	he Ho iin 24 h he Fui	Medical	(Check 2 Medical Examiner: only one) 3 Certifying Nurse P	On the basis of examinactitioner: To the bes	nation and/or inves at of my knowledge	tigation, in my opinio , death occurred at t	on, death occ he time, date	curred at the time, dat e and place, and due t	e and place, and du o the cause(s) and r	e to the cause(s) and manner stated. nanner as stated.
	To the within 2		29b. Signature and title of certifier			29c. License				d (Month, Day, Year)
	1		30. Name and address of person who comp	eyoul	(Item 23a) (Type, F		12452		June 2	27, 2012
	10			9715 Medic			21 Roc	kville, M	D 20850	
	Sta	te	31. Date filed (Month, Day, Year) 2012	22. Registrar's S	Signature					
	Registr	ar	JUN 20 2012	Cerous	p. Lyan	A ST.				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Departme		lental Hygi	ene 2012	20802
_		-	1. Decedent's Name (First, Middle, Last)	ate of Death	Re-	g. No. 💪 U I 💪	
	Physicia		Stella Skarbowski		Month June	26°, 20°12	3. Time of Death 11:00 P M
	Medio Examin			ty, Town, or Location of Death	0 0000	4c. County of Death	
				llicott City		Howard	
	Funeral		Month	der 1 Year If Under 24 Hrs. s Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birthp (ear) Count	lace (State or Foreign
	Director		086-20-9470		May 1,	1927 New	York
	land shov d at	tor	10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
	Mary 28a-f otifie	irec		licott City			1 🗆 Yes 2 🔀 No
	th the 3a or t be n	al D		Zip Code	10	g. Citizen of What Coun	·
	ath wi	Funeral Director	3225 Pine Bluffs Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	21042	cify Yes or No-	United Sta	
9	er deg or ite miner	by F	1 Never Married 2 Married 1 Yes 2 X No	edent of Hispanic Origin? (Spe pecify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	
200	ırs aft ural", IExa	per	3 ☐ Widowed 4 X Divorced If Yes, Give Year or Dates.	2 X No Specify:		Specify: Whi	.te
2	"nat "nat edica	ple	15. Decedent's Education 16a. Decedent's U (Specify only highest grade completed) (Give kind of v	vork done during most of worki.	ng 1	6b. Kind of Business/Inc	lustry
7	ithin ithin ithe.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  12  Factory			Factory	
D	iled w I Hygi othe ent, i	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		
/lar	d be f Venta venta arked artic ev	유	Vincent Drebot	Tecla	Pikol		
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland thand Mental Hygiene. ZT is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Medical Examiner must be notified at		r ·	ess (Street and Number or Rura			
	1 and 2 s of Health item 27 other tra			ne Bluffs Dr.			
000	- P = -		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory of	r other place)		Oc. Location - City or To	
Baltımore,	permit. Page Department Important: I any injury o		4 Donation 5 Other (Specify) Final Journey  21. Signature of Fungral Serylle Ligensee 22. Name			Woodbine,	
Ř	permit. Departr Import. any inji		Swulf Helle He MO1251 Bever	and Address of Facility Home Cramatio ly L. Heckrott	n Servica e, P.A. (	e 2.0. sox Clarksville	/84 , MD 21029
Н			23a. Part 1. Enget the disease, or complications that caused the death. Do not enter the m shock, or heart failure. List only one cause on each line.				Approximate Interval Between
P	hysician/		Immediate Cause (Final disease or condition  Metastatic Pancreati	c Cancer		6	Onset and Death WEEKS
1	Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		er	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):				
M	ted Insit	Examiner	cause, Enter Unidenying Cause (Disease or injury			-	
) *	be executed sician and burial-transit	Ex	that initiated events resulting in death) Last  C. Due to (or as a consequence of):				
_	requires that the death certificate be ex been signed by the attending physician should be detached for use as the burial	dical	d				
289	certificate nding physuse as the	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				-
Box	death ce he attend hed for us	cian	in the past 12 months?	c pregnancy (specify)		23d. Date of delive Month	ry Day Year
Ď.	he de y the sched	Physician/Me	1   Yes 2 X No 9   Unknown 9   Unknown	(aposity)			
л Э	that the ned by th e detach	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying	g cause given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?
ds,	quires en sig ould b				1 ☐ Yes	2 🛛 No 3 🗆 Prob	ably 4 🗆 Unknown
CO	law requires nas been sigi e 2 should be	Completed			24a. Was an autopsy	prior to cor	sy findings available npletion of cause of
۳ ب	The ate I pag				1 🗆 Yes 2		2 🗆 No
Ita	Physician; The this certificate ral director, pac	Be o	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1  Insertion: 3 FR/Outpatient 3	26. Place of Death (Check			
<u> </u>	y Physer this eral d	e: To	27. Manner of Death 28a. Date of injury 28b. Time of	DCA 4 ☐ Nursing Ho	me 5 X Residen 28d. Describe how	ce 6 Other (Specify)	
ם:	arth. rr. Afte	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation M	work? 1 🗆 Yes 2 🗆 No			
Division of Vital Records,	rr Atte ter de irecto	ertii	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, fact building, etc. (Specify)	ory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
בֿ <u>י</u>	oital o						
:	To the Hospital or Attending Physician; within 24 hours after death.  To the Funeral Director, After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check 2 ☐ Medical Examiner: On the bast of my knowledge, death occurred only one) 3 ☐ Certifying Nurse Practitioner: To the basis of examination and/or investigation, only one) 3 ☐ Certifying Nurse Practitioner: To the 65t of my knowledge, death of the basis of examination and or control of the basis of examination and or control of the basis of examination and or control of the basis of my knowledge, death or control of the basis of my knowledge, death occurred the basis of examination and or control of the basis of my knowledge, death occurred the basis of examination and or control of the basis of ex	in my opinion, death occurred at	the time, date and	place, and due to the cau	se(s) and manner stated.
	To the within To the Comp	2	<b>^</b> //	9c. License number		d. Date signed (Month, D	
			> Edward & heems	D23601		June 27, 20	12
	.\		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
	H		Edward J. Lee 10710 Charter Dr. Ste. G0 31. Date filed (Month, Day, Year) Registrar's Signature	<u>20 Columbia, M</u>	D 21044		
	Star Registra		31. Date filed (Month, Day, Year)  JUN 29 2012  Leave Signature				
-		_					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Strott III 2012 1:40P M June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Westminster 6530 Fathers Care Drive 5. Social Security Numbe Birthplace (State or Foreign Country)
 MD 8. Date of Birth **Funeral** 1 🗷 M 2 🗆 F Months Days Hours (Month, Day, ) Year) **Director** 218-26-4439 83 MD March Usual Residence of Decedent or items 23a or 28a-f show miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Westminster MD Carroll 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral death with USA 21157 2530 Fathers Care Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces? Black, White, etc. 2 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after White If Yes, Give 1 ☐ Yes 2 🗷 No Specify: "natural", Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traummit. Elementary/Seconday (0-12) College (1-4 or 5+) Potts & Callahan Estimator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lillian Heubner John C. Strott, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7047 MacBeth Way; Eldersburg, MD 21784 Daughter Laura Baggett 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6/28/2012 Pikesville, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Fyrieral Service Licensee 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or linjury that initiated events and resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical certificate be Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Live Grant 2 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Hospital or Attending Physician: The law requires that the death in the past 12 months? Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed has been si le 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) æ 2 No Hospital Other: 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA Funeral Director: After this of the funeral directions of the funeral 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pendina 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and time of certifie 29c. License number 29d. Date signed (Month, Day, Year) 26 2012 D0059552

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

C -

C-OURISHANKAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NAUANIA

DHMH 17 Rev 7/2009

TOUA POOLE RD WESTMINSTER MD

21150

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Spencer 1543 2012 Henry Medical 4c. County of Death N/A 4a. Facility Name (if not Institution, give street and number, Examiner 4b. City, Town, or Location of Death University of Maryland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) 217-74-8106 Director **№** M 2 🗆 F 02/23/1959 53 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Baltimore MD N/A 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 21217 1102 Druid Hill Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 X Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) mentary/Secondary (0-12) College (1-4 or 5+) Unemployed 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Beatrice Ridgley Henry L. Spencer Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2806 Baker St., Baltimore, MD 21216 Beatrice Spencer (mother) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State netery, crematory or other place)
Zion Cemetery Mt. 07/05/12 Baltimore, MD Donation 5 Other (Specify) gnature of uneral Service 30sephod科。Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD21217 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Sepsis isease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 28 days lymphoblastic leukemia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death the a igned by the bed be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Gastrointestinal bleeding 1 Yes 2 YNo 3 Probably 4 Unknown Human Immunodeticioncy Virus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death.
Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R13157

DHMH 17 Rev 06-2011

State

Registrar

South Greene Street Baltimore

Maryland 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ou-Ellen Lallier

JUN 29 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2005 Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month 11:00 MPM Jeffrey Scott Tutchton 26 20 Medical June 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 109 Longdale Rd. Timonium Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Min. Director 1 M A 2 - F 215-66-3255 Aug 16, 1958 Maryland 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director ral", or Items 23a or 28a-f s Examiner must be notified 1 Yes 2 No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 109 Longdale Rd 21093 United States 11. Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? 1 ▲ Yes 2 No If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc.) Completed by Black, White, etc. "natural", or 1 Never Married 2 Married Paga 1 and 2 should ba filed within 72 hours after nant of Haaith and Mantal Hygiana. ant: If item 27 is markad other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Divorced Specify: Year or Dates. 1977 - 1979 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Industrial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John Richard Tutchton Unk Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Tutchton /Wife 109 Longdale Rd. Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, ò Jun 28 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2012 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Mar 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attanding physician and I for usa as tha buriai-transit to the Hospital or Attending Physicien: The law requires that the death certificate be axacuted Cause (Disease of injuly that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day sata has baan signad by tha a paga 2 should ba datached i 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aftar this cartificata has I ☐ Yes 2 🗙 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🗷 Residence 6 🗌 Other (Specify) 1 ☐ Yes 2 🗙 No မ 1 Inpatient 2 ER/Outpatient 3 DOA the funarai 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury s aftar daath. 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be filiad in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a
To the Funeral D
compiataly filled Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Kertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

2300 Dulane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

31. Date filed (Month, Day, Year)

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ TITTLE CLARENCE 13 June 26, 1:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3850 Old Federal Hill Road Harford Jarrettsville 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Hours Director 215-28-8750 1 🕅 M 2 □ F 80 Aug. 22, 1931 Maryland 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗌 Yes 2 ੌNo Maryland | Harford Jarrettsville 10e. Street and Numbe ō 10g. Citizen of What Country? 23a Funeral 3850 Old Federal Hill Road 21084 USA permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. It files 27 is marked other than "natural", or items any injury or other traumatic event the Modification. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Xyes 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: 3 - Widowed 4 - Divorced Black Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Biological Technician 10 U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Franklin Tittle Sr. Mabel Augustus Watters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Shirley Marie Tittle /</u> Spouse 3850 Old Federal Hill Road. Jarrettsville, MD 21084 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State Bel Air Memorial Gdn; 6-30-2012 Bel Air, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. Signatur Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ demanha stage disease or condition resulting in death) 12 years Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No 1 Ves 2 No certificate director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
\_1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural 2 Accident injury 5 Pending Investigation after death Director: 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practition of T. the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State
Registrar

DHMH 17 Rev 06-2011

Kenwood

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5701

32. Registra 's Sig

Kloesz

D31295

Belhmore

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	4	57-18-2 Jsual Residence	807		M 2 □ F	94			Months I	Days Hours		(Month, Da December	ıy, Year,		Tex	untry)	Totale of Fores
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Funeral	11	. Marital Status	11005		. Was Dece	dent Ever i				t of Hispanic C				14. Race			dian,
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Physician/Medical		FEMALE: b. Was deceden	t pregnant	230	. If yes, out	come of pr	egnano	y						23d. Dat	te of del	ivery	
sicia		in the past 12	☐ No			nant at tim		death 3 ath 5	Other (spec					Mo	nth	Day	Year
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		3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could deterr			of Injury - ng, etc. (Sp		e, farm, stree	et, factory, c	ffice		28f. Location ( City or Tov			er or Rui	ral Rout	e Number,
<u>a</u>	2	ea. Certifier	1 Certifyin	g Physicia	ın: To the b	est of my k	nowled	dge, death o	ccurred at th	e time, date ar	nd place, ar occurred at	d due to the c	ause(s)	and mann	er as st	ated.	and manner s
Ιğ		CHICCH	Z INICUICAL	-Addition													
Medical	25		3 Certifyin	g Nurse P					death occurr		date and pla						

State Registrar BRIDGIT AZUNKARA, 31. Date filed (Month, Day, Year) JUN 29 2012

DHMH 17 Rev 06-2011

bare

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRIDGIT ALUNKARA, MD agol Middle of Center Duve, rodrille, mylal 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12<sup>Year</sup> Physician/ 2:10 a M William H. Traynham 27 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death lc. County of Death Baltimore Examiner Timomium Stella Maris Hospice 7. Age (*In y*rs. *last birthday*) 70 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Hours Min. 217-40-3956 X M 2 D F **Director** Yrs 1/18/42 MD Usual Residence of Decedent or 28e-f shov permit. Page 1 and 2 should be filed within 72 hours efter deeth with the Meryland Department of Heelth and Mentel Hyglena. Importent: If Item 27 is marked other then "neturel", or Items 23e or 28e-f sho any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic event, the Medical Examinar must be notified at once. 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore MD 1 Yes 2 Ty No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 W. Franklin St. #1001 21201 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Š المار على المار على المار المار المار Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates Amer. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Steel Elementary/Secondary (0-12) College (1-4 or 5+) Laborer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Fred Traynham Hattie Pettis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 W. Fayette St., Balt., MD 21223 Angela Trayham/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 6/28/12 Balt., MD Bayview Crem. 4 Donation 5 Other (Specify) 22. Name and Address of FacilityHari P. Clo 5126 Belair Rd, Balt., MD 21. Signature of Funeral Service Licensee Close Fasys PA 23a. Part 1. Enter the disease, accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Esophageal disease or condition Medical resulting in death) as a un uence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated events Examine Due to (or as a consequence of) certificate has been signed by the ettending physicien and irector, page 2 should be detached for use as the burlei-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 ☐ Yes 2 🔀 No Attending Physicien: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this s To the Hospitel or Attending PP within 24 hours effer deeth.
To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 1 📃 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Scertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 21093 30. Name and add ath (Item 23a) (Type, Print) MD 31. Date filed (Month, Day, Year) State 29 Registrar DHMH 17 Rev 06-2011

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/  $P^{M}$ Oleksandr Voropay 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Stella Maris Hospice Timonium 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral 8. Date of Birth Hours Days (Month, Day, Year) 214-75-5052 Director 1 X M 2 □ F 44 Yrs 10/31/1967 Ukraine 28a-f shov 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Important: If item 27 is marked other then 'natural'', or items 23e or 28a-f sho any Injury or other treumatic event, the <u>Medical Examiner must be notified at</u> death with the Maryland Director Maryland 1 Yes XX No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 10 Loomis Court 21117 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 87 2013 3 4 Maryland 21215-0036 1 Yes 2 No If Yes, Give X filed within 72 hours after 1 ☐ Yes 2 1√2 No Specify 3 Widowed 4 Divorced Specify: Completed White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 end 2 should be 1 Department of Health and Menta Important: If Item 27 is marked Tetiana Pastushenko Ivan Voropav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victoriya Voropay Wife 10 Loomis Court Owings Mills, Maryland 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) スカの 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Trinity Cemetery 06/30/2012 Elkridge, Maryland 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service License 6009 Harford Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only on cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospitel or Attending Physicien: The law requires that the death certificate being thours after death.

Funerel Director: After this certificate has been signed by the attending physicia O/e人sandで、 Voropa Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown g | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 N 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of gertifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) mo 210 31. Date filed (Month, Day, Year)
JUN 29 2012 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death dent's Name (First, Middle, Last) 3. Time of Death Ne Physician/ Sine 20 128 Medical acility Name (if not institution, give street and Town, or Location of Death 4c. County of Death **Examiner** -Medical TIMORE N/A7. Age (In yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Hours Min. 219-26-8483 **Director** 1 🛛 M 2 🗆 F 71 MARYLAND June 29 1940 Usual Residence of Decede 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State must be notified at Director 1 X Yes 2 No MARYLAND BALTIMORE N/A10g. Citizen of What Country? 10f. Zip Code ö 10e. Street and Number 23a Funeral U.S.A. 524 N. CHARLES STREET APT 612 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 67/71 1 ☐ Yes 2 X No Specify: Specify: BLACK "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 73 Health and Mental Hygiene. Item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) DISABLED N/A12yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ MAMIE VENEY ARTHUR VENEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 Shamrock Ave., Baltimore, Md., Alphonso Veney/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State injury or OWINGS MILLS, MARYLAND GARRISON FOREST 07 - 05 - 124 Donation 5 Other (Specify) Name and Address of Facility

1 C BROWN COMMUNITY

321 S PHILADELPHIA Y FUNERAL HOME-HARFORD P.A. BLVD, ABERDEEN, MD. 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: ves, outcome of pregnancy
Live Birth 2 - Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav Month 5 Other (specify) Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Vunknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ✗ No 24a. Was an autopsy performed? Yes 2 No filled in by the funeral director, page 2 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours.

To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Threnk 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 NORTH GREENE ST Baltom D 2120 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 2012 29 JUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend # 10c, per fh, g928 6-29-12 sm

State of Maryland / Department of Health and Mental Hygiene
amend 19a, per INF, g931 9-11-12 sm

Certificate of Death

Reg. No. 2 For State Registrar 2. Date of Death ent's Name (First, Middle, Last 3. Time of Death Day Physician/ Month lace. 1:40 PM mor 2010 6 JUNE Medical Oity, Town, or Location of Death ty of Death on, give str Examiner atonsvi more 8 yrs. last birthday, 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Bir Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 □ F **Director** or 28a-f show e notified at 10d. Inside City Limits 10c. City Town or Location 72 hours after death with the Maryland Director Catonsville 1 🗌 Yes 2 🗹 No TMOVE ተ////ዕ/۲ 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with une Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or Important: If item 27 is marked other than "natural", or items be a longitude of the magnitude of the magnitud 21228 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 12. 11. Marital Status Armed Black, White, etc 1 Never Married 2 Married 1 Yes If Yes, Give Completed by 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ₩Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) vorke Be ather's Name (First, Middle ပ္ ity or Town, State, Zip Cod 19b. Mailing Aumono -God Daughter 20b. Place of Disposition cemetery, cremator Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) rices Standture of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cerebro rascular acciclent 1 year disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Hyperotension 1042 Sequentially list conditions, it can be in the immediate cause. Enter Underlying Cause (Disease or iinjury Due to o a conse uence of: Examine Hychoce phalus attending physician and for use as the burial-transit 140 To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last mellitus 10 400 Physician/Medical Dlabetis Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a d be detached f Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 2 No 3 Probably 1 Yes Completed within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 M No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 🗹 Natural 5 Pending 1 Yes 2 No M Investigation Could not be Accident 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 6126/12 D30494 1055-KDETHIM an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balhmore MD 21228 DESH/m 716 maidenchoice lane 31. Date filed (Month, Day, Year) 32. Registrar's Signature State back 29 2012 Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	State of Maryland / Departn State Registrar  State of Maryland / Departn Certific	nent of Health ar		liene leg. No. 201	2 20812
Physiciar	_	1. Decedent's Name (First, Middle, Last)  Carol Ann Wetmore		2. Date of Deat Month		3. Time of Death
Medica Examine			City, Town, or Location of D Bethesda	Death	4c. County of Dea Montgon	th
Funeral Director			Under 1 Year If Under 24 nths Days Hours	Hrs. 8. Date of Birth Min. (Month, Day, Feb 6,	Year) Co	thplace (State or Foreign buntry) W York
ryland I-f show ied at	ctor	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
the Ma a or 28a be notif		MD Howard Columbia 10e. Street and Number 10	Of. Zip Code		10g. Citizen of What Co	
ems 23	Funeral Director	6217 Three Apple Downs  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was D	21045 Decedent of Hispanic Origin		USA 14. Race - Ame	erican Indian
0036  urs after de ural", or it I Examine	&	1 L Never Married 2 L Married 1 L Yes 2 V No	Decedent of Hispanic Origin specify Cuban, Mexican, P	Puèrto Rićan, etc.)	Black, Whit	e, etc.
Baltimore, Maryland 21215-0036  permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	(Specify only highest grade completed) (Give kind of life. DO NO l	Usual Occupation of work done during most of Tuse retired) nistrator	f working	16b. Kind of Business	
land 2 be filed w ental Hygi rked other ic event, t	ωŀ	17. Father's Name (First, Middle, Last)  Charles William Cline	18. Mother's	s Name <i>(First, Middle, N</i> eronica Mai	faiden Surname)	
e, Marylanc and 2 should be file Health and Mental I Hear 27 is marked o ither traumatic eve		19a. Informant's Name/Relationship (Type, Print) Allison Williamson/daughter 19b. Mailing Add 6217 Th	dress (Street and Number of Page Apple Do	or Rural Route Number, wns Columb	City or Town, State Zi	543 <sup>de)</sup>
imore, I Page 1 and 2 ment of Healt ant: If item 2 ury or other i		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)		Date	20c. Location - City or	Town, State
Baltimo permit. Page Department of Important: If any injury or			rendAnaromyllibe timore, MDS	oard 655 W. 21201	Baltimore	Street
Ph. i. i. n. Medical Examiner  Ph. Medical Examiner  Ph. Medical  Ph. Medical  Ph. Medical  Ph. Medical  Ph. Medical	dical Examiner	23a. Part 1. Inter the disease, of complications that caused the death. Do not enter the shock, of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):			st,	Approximate Interval Between Onset and Death Address A
box b8 // death certifica he attending pl hed for use as t	Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	opic pregnancy er (specify)		23d. Date of de Month	livery Day Year
uires that the n signed by t	≧	Part II. Other significant conditions contributing to death but not resulting in the underly	/ing cause given in Part I.		pacco use contribute to	the cause of death?
VItal HeCordS, uysician: The law requires is certificate has been sig director, page 2 should b	Completed			24a. Was ar autops perform	y prior to	topsy findings available completion of cause of
VITal vsician: s certific director,		25. Was case referred to medical examiner?  1  Yes 2  No	26. Place of Death (			16.1
on or anding Phyath.	ceruncate: 1	27. Magner of Death    1	28c. Injury at work?	28d. Describe ho		iiy)
DIVISION tal or Attendir rs after death. al Director Af ed in by the fu		3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	ctory, office	28f. Location (Str City or Town,	reet and Number or Ru , State)	ral Route Number,
the Hospi nin 24 hour the Funer npletely fill	Med	29a. Certifier  (Cherk 2 Nucleus Faminer: On the basis of examination and/or investigation only one)  3 Certifying Nurse Practitioner: To the best of my knowledge, death	<ul> <li>n. in my opinion, death occur</li> </ul>	rred at the time, date and	d place, and due to the	cause(s) and manner stated
To with con		29b. Signature and the or certifier hashes lascusa	29c. License number		9d. Date signed (Month June 22, 20	
		30. ame and address of person who completed cause of death (Item 23a) (Type, Print) Philip Charles Corcoran Suburban Hos	pital Bethe	sda,MD 208	814	
State Registrar		31. Date filed (Month, Day, Year)  JUN 29 2012  32. Registrar's Signatur  Auct	W	***		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death 3. Time of Death Physician/ 05:15 PM awa Karaya lage Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Ba ospice WSON crest If Under 1 Year | If Under 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 24 Hrs. **Funeral** Days Hours Min. (Month, Day, 217-73-Director 1 🗆 M 2 🔀 F 29 Sri ank 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits at the Maryland Director ns 23a or 28a-f s must be notified 1 🗌 Yes 2 🔀 No Mary and 10e. Street and Number tiMore 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral anka "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death <sup>o</sup> Department of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Asian 3 Divorced Year or Dates. er than "natur , the Medical B 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) uth and Mental Hygiene.

27 is marked other than traumatic event, the N Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Wedikarayalage amad 19a. Informant's Name elationship (Type, Print) 19b. Mailing Address (Street and Number or Sepali A Rajapaksa L Ralalage/Husband 20a. Method of Disposition 20b. Pla 45 Alle, Mary Crossing Department of Health Important: If item 27 any injury or other to once. hand 10 Kings Cros 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 30/2017 Signature of Funeral Service C. Jones Funeral Home, P.A. Park 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phy i ian disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence hours after death. neral Director: After this or y filled in by the funeral dii 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Sig and title of 29d. Date signed (Month, Day, Year) D0071187 30. Name and address of person who completed cause of death (Item 23a) (Type Print) #4105, Baltruck, Charolese State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5. OAM Sabrina Washington UNG 2012 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Dea MESICAL ANHE ALTIMORE INASHINGTON BURNIE UNDE If Under 24 Hrs. 8. Date of Birth (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Min (Month, Day, Director 111-50-7450 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 644 Ridgefield 21061 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 2 If tes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 2th grade Business Office Manager Genesis Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George McClain Glenda Hendricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Sharida V. Jackson-Daughter 1822 Village Square Ct., Severn, Md 21144 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Donation 5 Other (Specify) King Memorial Park 7/2/2012 Woodlawn, Md 21. Sign tute of Funeral Service Licensee 22. Name and Address of Facility 300 Wabash Baltimore, Md 21215 Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart foliure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph, sician TAKTATIC disease or condition Medical resulting in death) Examiner Sequentially list conditions Examiner Due to (or as a consequence or) cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month signed by the sid be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy performed? Yes 2 death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🖪 No Hospital Other: 1 Tyes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation Director: / 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29c. License numbe 30. Name and address of person who complete ed cause of death (Item 23a) (Type, Print) >01

Registrar

State

32. Regist

WILSON, HOWARD

			Please T	ype or Print in Black In				•
		1	For State Registrar	State of Maryland / Depa Cert	rtment of Health fificate of Death		Reg. No. 20	2 20815
1	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Year	3. Time of Death
	Medic Examin	al .	HOWARD LEE WILSON  4a. Facility Name (if not institution, give str	eet and number)	4b. City, Town, or Location		25 ZoiZ 4c. County of Dea	th
named .			FRANKLIN SQUARE 15. Social Security Number   6. Sex	HOSPITAL CENTER  7. Age (In yrs. last birthday)	ROSE OF	PLE er 24 Hrs. 8. Date of Birl	BALTI	MORE thplace (State or Foreign
	Funeral Director	irector	219-18-6846	M 2   F   84   Yrs.	Months Days Hours		y, Year) Co	muntry) MD
	Maryland -28a-f show notified at		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Loc NOTTINGHAM	ation			10d. Inside City Limits
			MD BALTIMORE  10e. Street and Number	NOTTINGIAL	10f. Zip Code		10g Citizen of What C	1 Yes 2 X No
	with the	eral	198 JUMPERS CIRCLE	UNIT 66	21236		10g. Citizen of What C	
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Health and Mental Hygiene.  The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 X Married  3 □ Widowed 4 □ Divorced	Armed Forces? If	/as Decedent of Hispanic C Yes, specify Cuban, Mexic ☐ Yes 2 X No Specif	an, Puerto Rican, etc.)	14. Race - Am Black, Whi Specify:	
15-0	72 hour "natur ledical	Completed	15. Decedent's Edu (Specify only highest grade	cation 16a. Decede (Give k	ent's Usual Occupation ind of work done during mo NOT use retired)	ost of working	16b. Kind of Business	
21215-0036	within giene.	e Con	Elementary/Secondary (0-12)	College (1-4 or 5+)  PAINTE			MANUFACT	UKING
aryland	be filed ental Hy rked oth ic event	0	17. Father's Name (First, Middle, Last) ROBERT WILSON			ther's Name (First, Middle, ZABETH GIBS		
	2 should be file th and Mental I 27 is marked o traumatic eve	3	19a. Informant's Name/Relationship (Type BARBARA WILSON-WIFE	e, <i>Print</i> ) 19b. Mailin	g Address (Street and Num	iber or Rural Route Numbe JNIT 66 NOT	er, City or Town, State, Z TINGHAM, MI	jp 21236
ore,	permit. Page 1 and 2 sł Department of Health a Important: If item 27 is any injury or other tra		20a. Method of Disposition  1 □ Burial 2 X Cremation 3 □ R	emoval from State 20b. Place of Dispos cemetery, crem	atory or other place)	Date	20c. Location - City o	
Baltimore,	artment artment ortant: injury o		4 ☐ Donation 5 ☐ Other (Specify)  21. Signal of Funer, Service Licensee	ATLANTIC	CREMATORY  Name and Address of Fac	6/26/12	GLEN BURN	
Ba	регтіі Depar Impor any ir	1)	Strolly	97	05 BELAIR RD	NOTTINGHAM	1, MD 21236	11
1			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only one Immediate Cause (Final	_	r the mode of dying, such a	as cardiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
Physician/ Medical		1	disease or condition resulting in death)	a. PNE MONIA  Due to (or as a consequence of):				
	Examiner	er	Sequentially list conditions,	DEMENTIA  Due to (or as a consequence of):				
	ecuted and al-transit	xamine	if any, leading to immediate cause. Enter Understand Cause (Disease or injury that initiated events					
_	⊛ E :≅	ш	resulting in death) Last	Due to (or as a consequence of):			;	
3760	ficate k g phys as the	Medic	IF FEMALE:					
Box 68760	Physician: The law requires that the death certificate be exerthis certificate has been signed by the attending physician areal director, page 2 should be detached for use as the burial	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy 1	Ectopic pregnancy Other (specify)		23d. Date of d Month	elivery Day Year
P.0	requires that the des been signed by the s should be detached	ğ	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Pa		tobacco use contribute	to the cause of death?  Probably 4 💢 Unknown
ords,	require been si should	eted				24a. Was	an 24b. Were a	utopsy findings available
3ecc	The law rate has be page 2 s	Completed				auto	ormed? death?	es 2 No
tal	ician; The certificate rector, paç	Be	25. Was case referred to medical examiner?	ospital:	Other	eath (Check only one)		
J V	Physic r this c eral din	Medical Certificate: To I	27. Manner of Death	1 Inpatient 2 ER/Outpatier  28a. Date of injury 28b. Time of	28c, Injury at	Nursing Home 5 Resi	idence 6 Other (Spe how injury occurred	ecify)
ion	Attending or death. ector: After by the fune		1 X Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) injury	work? M 1 ☐ Yes 2		7) / IN	hum I Deute Mumber
Division of Vital Records, P.O.	al or Att s after d   Direct d in by		4 Homicide determined	28e. Place of Injury - At home, farm, stre building, etc. (Specify)	eet, factory, office		Street and Number or F wn, State)	ura noute ivariber,
1	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,		(Check 2 Medical Examin	cian: To the best of my knowledge, death or er: On the basis of examination and/or invest	tigation. In my opinion, death	occurred at the time, date	and place, and due to the	e cause(s) and manner stated
	To the within ? To the comple	Ž	only one) 3 L Certifying Nurse	Practitioner: To the best of my knowledge	death occurred at the time, 29c. License numbe		29d. Date signed (Mor	
	1.0		> Ahmad	MD	0613	37	6/25/12	

State Registrar DHMH 17 Rev 06-2011 BALTIMORE, MD 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KIRMANT AHMED 9000 FRANKLIN SQUARE DR.,
31. Date filed Month Day, Xari 2

32. Registrary Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** MYNN DOLORES 10:40 AM 8 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2**X**) F Days 212-22-0141 Maryland August 23, 1926 **Director** Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits shov or 28a-f shoven Dundalk Director Maryland Baltimore 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? with ò ral", or items 23a o Examiner must be 21222 USA 3400 Yardley Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 1 Tes If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ò 3X Widowed 4 □ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) d Mental Hygiene. marked other than the Baltimore County 10 years Bus Driver 27 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret C. Boeh John G. Kaufman မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 3406 Court Way, Dundalk, Maryland 21222 Daughter Janet Jakubowski other 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If ite
any Injury or ot 1 XBurial 2 Cremation 3 Removal from State Marriottsvile, Maryland Crest Lawn Cemtery 4 Donation 5 Other (Specify) 2012 21. Signature of Fune al Service Licen 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222 23a. Part 1. Enter the disease, of complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final Physician Freumonio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Listage or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events burial-trar and resulting in death) Last Due to (or as a consequence of) Box 68760, physiciar Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy for Day Year 4 Pregnant at time of death 5 Other (specify) ed by the at detached for 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?

1 Yes 2 No Hospital: Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မ 28a. Date of Injury
(Month. Day Year) this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural
2 Accident ours after death. eral Director; Af filled in by the fu 1 Yes 2 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Funel completely fi Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000

State Registrar

DHMH 17 Rev 1/2001 11595 4940 Eastern Avenue, Baltimore, MD, 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2012 5:06 P M June 27, Morrison B. Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday, **Funeral** (Month, Day, Year) Months Days Hours 230-20-8550 1 X M 2 □ F **Director** 89 Vrs Mar. 29, 1923 Wisconsin Usual Residence of Decedent show. 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director must be notified 28a-f Thomasville 1 Yes 2 X No PΑ York 10f Zip Code 10e. Street and Number 10g, Citizen of What Country? 23a Funeral 17364 United States 485 Sunset Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. o þ 1 Never Married 2 Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced WWII "natural" Completed Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Law Attorney event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, f Health and Mental H item 27 is marked ot Aubrey W. Williams Anita Schreck Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5600 Northfield Road, Bethesda, Maryland Jean E. Williams/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State i o i 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. Montgomery Crematorium Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M01173 Robert A. Pumphrey Funeral Home, 7557 Wisconsin Avenue, Bethesda, 21. Signature of Funeral Service License Bethesda-Chevy Maryland 20814 Chase, Inc. Milleri 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical 68760 use as tending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 8 Yes 2 No the 9 Unknown 9 Unknown Records, P.O. ģ Willams, Morrison Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe Gastrointestinal Bleed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperkalemia autopsy performed? Yes 2 X N 1 Yes 2 No this certificate 1 Yes director. 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗶 No P 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 🔀 Naturai 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29d. Date signed (Month, Day, Year) 29b. Signature and June 27, 2012 D0061302 30. Name and and ess of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Atul Rohatgi, M.D.

31. Date filed (Month, Day, Year) **JUN 29 2012** 

8600 Old Georgetown Road, Bethesda, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Wes Jasn /Medical 4a. Facility Name (If no institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Director 58 03/12/1954 MD 218-60-4410 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f show must be notified at Director 1 XYes 2 ☐ No Baltimore MD n/a 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21213 USA 3317 Lyndale Avenue Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Examiner 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 21215-0036 þ 1 ☐ Yes 2 No Specify Specify **Black** 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Gray and Son Elementary/Secondary (0-12) College (1-4 or 5+) Cement Finisher Construction Company Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 is marked o any Injury or other traumatic ever Herbert West Cleopatra Crump 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvanne West / Wife 3317 Lyndale Avenue Baltimore, MD 21213 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 3,2012 On-Site Cremation Baltimore, MD 21. Signature of Funeral Service Lice John L. Williams Funeral Directors, P.A 4517 Park Hohts Ave Baltimore, MD 21215 23a. Par 1. Pnter the disease, or complications that cased the shirk, or heart failure. List only one cause on each ine. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary **Physician** 10001 /Medical Due to (or as a consequence of): **Examiner** bacco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence or) or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Yes 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 XNo 1 Yes 2 No 1 Tes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital: 1 Inpatient Other: 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home မ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural Injury 5 Pending investigation 1 Yes 2 🗌 No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only Medical one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RFS-000 June 27,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tanya Williams

DHMH 17 Rev 1/2001 11595

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death Physician/ JUNE 23 2012 ear 5:15 ам WILEY MARGARET MARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death SOMERFORD ASSISTED LIVING HOWARD COLUMBIA Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Director 216-20-0301 1 M 2 XF MAY 9,1925 87 MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 X Yes 2 No MD N/A BALTIMORE ō 10e. Street and Number 10g, Citizen of What Country? 23a Funeral 21224 3918 FOSTER AVENUE U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 XVidowed 4 Divorced WHITE Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC permit. Page 1 and 2 should be filed win Department of Health and Mental Hygie Important: If item 27 is marked other amy injury or other traumatic event, til Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည THOMAS LARDNER MARGARITE FITZGERALD Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2925 NEW YORK AVENUE, BALTIMORE, MD KATHLEEN YEAGER/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) SACRED HEART OF JESUS 6/28/1 2 BALTIMORE, MD LILLY & ZEILER INC. FUNERAL HOME 700 S. CONKLING STREET, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to him ediate cause. Enter Underlying Cause (Disease or injury Examine Due to for easy consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the 38 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 ☐ Yes 2 🔼 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 💢 No Other: 4 Nursing Home 5 Residence 6 X ASSISTED LIVING ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Investigation 6 Could not be Accident Director: 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4  $\square$  Homicide determined 24 hours Medical XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Notice Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) D47447 30. Name and address npleted cause of death (Item 23a) (Type, Print) ANDREW ZRIS.M.D. 6334 CEDAR LANE #103, COLUMBIA, MARYLAND 21044 32. Registrar's Sign ture Registrar

12-04732 Baby Williams

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ouby Williams	1-For State amend 7 per fh g928 7/204111202	e of Death	Reg. No. 2012 2082		
Physician/ Medical Examiner		2. Date of D Month June 23			
	Part Baby Girl Williams  4a. Facility Name (if not institution, give street and number)  Maryland General Hospital  4b. City, Town, or Location of Death  Baltimore  Month Day Year  June 23, 2012  4c. County of Death  N / F				
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthd: N / A 1 M 2 X F	Mantha Davis Haves Min	Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign CourMM)		
Aaryland 28a-f show any Lat once. Octor	Usual Residence of Decedent   10a. State		10d. Inside City Limits 1 X Yes 2 No		
the Maryland 3a or 28a-f sh ptified at once	10e. Street and Number 2013 Druid Hill Ave	10f. Zip Code 21217	10g. Citizen of What Country? USA		
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland fealth and Mental Hygiene.  tem 27 is marked other than "natural", or items 23a or 28a-fabo traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	15 Decedent's Education (Specific columbiated grade completed) 150 Decedent grade grad	3. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 Yes 2 No specify: cedent's Usual Occupation (Give kind of work done)	No- 14. Race - American Indian, Black, White, etc. African SpecifyAmer.  16b. Kind of Business/Industry		
215-0036 be filed within 72 hours at ntal Hygiene. ked other than "natural ent, the Medical Examin Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)  O	ing most of working life. DO NOT use retired)	N/A		
21215-0036 uld be filed within 7 Montal Hygiene. marked other than marked other than cevent, the Medica.	Charles Harper	18. Mother's Name (First, Middle Lachisa A. V	Villiams		
e, MD 21 1 and 2 should Health and Me item 27 is man r traumatic ev	Rosa Williams/Grandmother 20	Mailing Address (Street and Number or Rural Route N 13 Druid Hill Ave, Bal Disposition (Name of cemetery, Date	umber, City or Town, State, Zip Code) Lt., MD 21217  120c. Location - City or Town, State		
Baltimore, permit Pages 1 ar Department of Hec Important: If ite	1 X Burial 2 Cremation 3 Removal from State crematory 4 Donation 5 Other Specify	ion Cem. 6/30/12	Balt.,MD		
		<sup>22. Name and Address of Facility</sup> Hari P. 5126 Belair Rd, Balt.,	MD 21206-5105		
Physician Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Prematurity with complications  Death  Due to (or as a consequence of):				
iner	Sequentially list conditions, b.				
cuted nd transit I Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.				
'60, rate be execu physician and re burial - tr.	■ UNPENDED □ AMENDED 23a,27,per m	e,g929 7-30-12 sm			
Sox 687 leath certific e attending p for use as th	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Fetal death 3 Ectopic pregnancy Other (Specify)	23d. Date of delivery  Month Day Year		
ires that the displaying signed by the displayed by the detached by the detached by the displaying by by Phy			tobacco use contribute to the cause of death?  'es 2 No 3 Probably 4 V Unknown		
Division of Vital Records, F tal or Attending Physician: The law requires rs after death.  al Director: After this certificate has been signed in by the funeral director, page 2 should be artification: To Be Completed		1 <b>✓</b> Yes	24b. Were autopsy findings available prior to completion of cause of death?  1 Ves 2 No		
Vital ysician: ysician: his certif director,	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpa	26.Place of Death (Check only one)  atient 3 DDA Other Nursing Home 5	Residence 6 Other:		
Division of a tee Hospital or Attending Plu within 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral edical Certification: Teedical Certification: T		e of Injury 28c. Injury at Work? 28d. Describ	e how injury occurred		
Division o spital or Attending nours after death. nearal Director: Aft filled in by the fune Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, (Specify)	street, factory, office building, etc. 28f. Location or Town,	(Street and Number or Rural Route Number, City State)		
To the Ho within 24 F To the Fu completely	29a. Certifier (Check only one)  2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) June 24, 2012		
	30. Name and address of person who completed cause of death (Item 23a)  Ling Li, MD Assistant Medical Examiner 900 W. Balt				
State Registrar	31. Date filed (Month, Day, Year)  JUN 2 9 2012  32. Registrar's Signature	back			

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Benjamin Young Medical County of Death 4a. Facility Name (if not institution, give street and number) Baltimo **Examiner** Rose HOS dale squar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Min Country) **Director** infant 1 XM 2 □ F June 17, 2012 Maryland 20 Show 10d. Inside City Limits ge 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hyglene. If fleth 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Glen Burnie Anne Arundel MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral USA 21060 1010 Fitzallen Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Yes, Give 'oung, Benjamir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify black Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) infant Elementary/Secondary (0-12) infant infant infant Be unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ဂ Tameika Young 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 21237 900 Franklin Sqaure Drive Rosedale, MD Franklin Square Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in state Funeral S n e Licensee <sup>22</sup> State Anatomy Board 655 W. Baltimore Street Virector Baltimore. MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nknour Physician/ Medical resulting in death) **Examiner** Sequentially list conditions. rupture of membranes cause. Enter Underlying Exami Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last nding physiciar Physician/Medical 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atten in the past 12 months? 1 Yes 2 No Month Year Day Pregnant at time of death Other (specify) ned by the a detached f g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ been signer should be c 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate:

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death ie Funeral Director: A bletely filled in by the f within 24 ho

To the Fune

completely f

28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

9000 Franklin Square Dr. Balto, MD, 212

State

Medical

only one

29b. Signature and title of certifie

oleted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

Registrar

0 2 2012

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jude Odiase Atiomo State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2012 208							
Physician/ Medic Exami		1. Decedent's Name (First, Middle, Last)  JUDE Ocli 45e Ationo	2. Date of Dea Month Jurie 24,				
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lo Laurel Regional Hospital Laurel		4c. County of Death Prince George's			
Funeral Director		5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year 231-87-5332 1 M 2 F 39 Yrs.		irth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) - 1973 NIGERIA			
ny	ļ	Usual Residence of Decedent  10a State 10b, County 10c, City, Town or Location		10d. Inside City Limits			
and show as	Director	MD Prince Georges BELTSVILLE		1 Yes 2 No			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teafth and Metal Hygiene tern 27 is marked other than "natural", or items 23a or 23a-f show any traumatic event, the Medical Examiner must be notified at once.		10e. Street and Number 10f. Zip Code 2070		10g. Citizen of What Country?  USA			
eath with teems 23	Funeral	11. Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispar 14. Merital Status 15. Was Decedent of Hispar 16. Merital Status 16. Was Decedent of Hispar 17. Merital Status 18. Was Decedent of Hispar 19. Merital Status 19. Was Decedent Ever in U.S. 19. Merital Status 19. Was Decedent of Hispar 19. Merital Status 19. Meri	nic Origin? ( Specity Yes or No Mexican, Puerto Rican, etc.)	White, etc.			
s after de tral", or	by Fu	3 Wildowed 4 Divorced If Yes, Give Year 1 Yes 2 No a		Specify: BUACK			
5 72 hour un "natu	eted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)		16b. Kind of Business/Industry  PRIVATE			
21215-0036 ould be filed within 7 Mental Hygiene marked other than	Completed	4 RETA IL  17 Father's Name (First, Middle, Last)  18.	Mother's Name (First, Middle, I				
21215 Ild be file Mental H narked event, ti	To Be (	ANSELM ATIOMO  19a. Informant's Name/Relationship (Type, Print.)  19b. Mailing Address (Street)	VICTORIA and Number or Rural Route Nu	SAMUEL  Tiber, City or Town, State, Zip Code)			
ore, MD 21215-0036 s: 1 and 2 should be filed within 72 hours after death with the Figelse. If teen 27 is marked other than "natural", or items 23a nor traumatic event, the Medical Examiner must be not	٦	Anselm ATIUMO BrUTHER 3813 EVANS	TRIAL CT; BE	LTSVILLE, 40 20105			
		20a. Method of Disposition  20b. Place of Disposition (Name of cemet crematory or other place)  4 Donation 5 Other Specify  20b. Place of Disposition (Name of cemet crematory or other place)  4 Donation 5 Other Specify		20c. Location - City or Town, State			
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If teen 27 is marked other thingury or other traumatic event, the Mac		4   Donation 5   Other Specify   Ywwy War Institute   Donation 5   Other Specify   Ywwy War Institute   22. Name and Address of BIAWCH	Facility				
Physician		23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such failure. List only one deuse on each line.					
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a Seizure Disorder  Due to (or as e consequence of):		Death			
	Je.	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):					
.22	Examine	cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last  Due to (or as a consequence of).					
760, icate be executed physician and the burial - transit	ह	MENDED 23a,27 per fh g930 8-24	4-12 <b>v</b> t				
60, ate be	Medi	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery			
687 ertific	cian/I	past 12 months?	Ectopic pregnency	Month Day Year			
Box 68 e death certif the attending ed for use as	ysic	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown					
P.O. Box 68's that the death certificated by the attending to detached for use as!	by Physic	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given		obacco use contribute to the cause of death?  s 2 X No 3 Probably 4 Unknown			
1 of Vital Records, P.C ing Physician: The law requires that After this certificate has been signed funceal director, page 2 should be deta	Completed		24a. Was				
Reco	ошо		1X yes	ormed? death?			
tal F	BeC	evaminer?	Death (Check only one)				
of Vit		1 X Yes 2 No I impaller 2 X Errocupation 3 Dock  27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury 2		Residence 6 Other:			
ion C tending eath or: Af	딅	(Month, Day, Year)	2 No				
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that than an after death.  Pal Director: After this certificate has been signed by leed in by the funeral director, page 2 should be detach.	ertification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office built (Specify)	ding, etc. 28f Location ( or Town,	Street and Number or Rural Roule Number, City State)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and compiletely filled in by the funeral director, page 2 should be detached for use as the burnal – transi	edical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete a cone)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.					
४न्≰न	Me.	29b. Signature and title of certifier 29c. License n		29d. Date signed (Month, Day, Year)			
		functly bushalf, MS O.C.M.	<b>E</b> .	June 25, 2012			
8		30 Name and address of person who completed cause of death (Item 23a)  Pamela E. Southall, MD Assistant Medical Examiner 900 W. Baltimore St	reet, Baltimore, MD 212	223			
State 31. Date filed (Month, Day, Year) 32. Registrar 32. Registrar							
ADDICAL DE LA							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 05 M Physician/ Month 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** HIMORE ICK TIMORE 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Director 1 □ M 2 🌠 F 82 28a-f show 10b. County 10c. City, Town or Location by Funeral Director 1 X Yes 2 ☐ No TIMORE 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21229 Frederick 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces 1 Never Married 2 Married 2 No ŏ Yes Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates HMERICAN "natural" 3 ☒ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4 or 5+) ome maker is marked other Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) 0 /RAVERS RANK 19a, Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. BARBAra 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Centery Ecollawy MARGIAND 22. Name and Address of Facility
NANCY M. WAILARE FUNERAL SERVICE
3405 W. FRANKLIN Street - BAttomore e of Funeral Service Licensee MAKYlAnd 21229 Pair 1. Enter the cisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart frillure. List only one cause on each line. Interval Between Onset and Death Immediate Cause [5] al NEUMONIA Physician/ disease or condition Medical resulting in death) as a consequence of) **Examiner** DISDRDER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Records, Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Hospital or Attending Physician: The g 1 Tes Was case referred to medic examiner? Division of Vital 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred iniurv work? 1 X Natural 5 Pending 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie araz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 31. Date filed (Month. Day, Year) Registrar

12-04825 Samuel Agostini

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	2 21	082
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		1- For State Registrar	Certific	ate of Death	na Mentari		ZUI	2 2082
Physic Medical Exam		Decedent's Name (First, Middle,Last)     SAMUEL AGOSTINI				2. Date of Deat Month June 27, 2	h	3. Time of Death 1216 hrs
		4a. Facility Name (if not institution, give street an University Hospital	d number)	4b. City, Town, o	or Location of Dear		4c. County of Death NA	1
Funera Director		5. Social Security Number 219-19-4903 6. Sex	7. Age (In yrs. last birt 24	hday) If Under 1 Ye Months Da		_	TEORDIC	thplace (State or gn untry) MD
Maryland 28a-f show any	or	Usual Residence of Decedent  10a. State 10b. County  MD HARFORD	10c. City, Town BEL AI					10d. Inside City Limits 1 Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once,	Director	10e. Street and Number 302 LOCUST LANE		<sup>102</sup> Zip Gode 2 I 0 1 4		10	g. Citizen of What Cou	ntry?
her d	币		Year	13. Was Decedent of H If Yes, specify Cuba  1 Yes 2 N Decedent's Usual Occup.	o specify:	Rican, etc.)	White, etc.	can Indian, Black, HITE
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours at ment of Health and Mental Hygiene.  Tant: If item 27 is marked other than "natural or other traumatic event, the Medical Examin	Completed	Elementary/Secondary (0-12) Colleg	ge (1-4 or 5+)	during most of working lif	e. DO NOT use ref	ired)	CAR WASH	Trial of y
21215-0036 And be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name (First, Middle, Last)  ROBERT AGOSTINI			PAMELA			
MD 2 nd 2 shoul alth and M m 27 is m	2	19a. Informant's Name/Relationship (Type, Print ) PAMELA AGOSTINI-MOTHE	ER	Mailing Address (Stre 302 LOCUST				
Baltimore, MD permit. Pages 1 and 2 sh Department of Health an Important: Mitem 27 is injury or other traumat		20a. Method of Disposition  1 Burial 2 Xcremation 3 Remov  4 Donation 5 Other Specify:  21. Synature of Funeral Service Licensee	al from State cremato	f Disposition (Name of co ory or other place)  VTIC CREMATO  22. Name and Addres	ORY 7	Date / 2 / 1 2	GLEN BURN	IE, MD
		236. Part I. Enter the disease, or complications th	L	610 W. MA	ACPHAIL R	D BEL A	IR, MD 210	
Physician /Medical Examiner		Immediate Cause (Final disease a. Multiple	Blunt Force Injuries	t enter the mode of dying	, such as cardiac (	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and Death
	Je.	Sequentially list conditions, b.	as a consequence of):					
ed ssit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated	as a consequence of):					
760, icate be executed physician and the burial - transit	edical	d. UNPENDED AMENDE	D					
ox 68 eath certif attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	es, outcome of pregnancy re birth 2 egnant at time of death 5 known	Fetal death 3 Other (Specify)	Ectopic pregna	incy	23d. Date of delivery Month Da	ay Year
i, P.O. Baires that the designed by the	ğ		g to death but not resulting	in the underlying cause	given in Part I.		acco use contribute to the 2 No 3 Proba	
of Vital Records, ag Physician: The law require the criticate has been sinneral director, page 2 should be	Completed					24a. Was ar autopsy perform	24b. Were auto prior to co	opsy findings available empletion of cause of
Vital Rec ysician: The his certificate director, page	To Be (	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Inpatient 2 🗸 ER/Out		of Death (Check of Other Nursin		esidence 6 Other:	
ion of tending Pheath.	ation: T	27. Manner of Death 28a, Da	ate of Injury 28b. Ti nth Day Year) 1051		ry at Work? Yes 2 ✔ No	28d. Describe ho Driver motoro	w injury occurred cycle truck collision	1
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined (Specific Specific Sp	lace of Injury - At home, fan	m, street, factory, office b		or Town, Sta	reet and Number or Rura te) nd Reckord Road, Fa	
To the Howithin 24 h To the Funcompletely	Medical	29a. Certifier (Check only one)  2 Medical Examiner: On the base and manner.	is of examination and/or inv	estigation, in my opinion	n, death occurred a	t the time, date an	nd place, and due to the	cause(s)
		29b. Signature and title of certifier	DN	29c. Licens O.C.I		1	29d. Date signed <i>(Mont</i> June 28, 2012	h, Day, Year)
H Wy			ause of death (Item 23a)  Medical Examiner	900 W. Baltimore	Street, Baltim	ore, MD 2122	23	
St Regist		31. Date filed (Month, Bay, Year) 32.	Registrar's Signature	harles			OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #8 PerFH G930 8/03/2012 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar 20826 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 Day 252 unaylah Allen une 10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death The Johns Hopkins Baltimore MD Hospital 8. Date of Birth 2010 5. Social Security Number UNK 6. Sex If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Country) Days 2 / 12 / 201 2 Director 1 DM 2 DXF Usual Residence of Decedent 28a-f shov at 10a. State 10b County 10c. City, Town or Location Director 10d. Inside City Limits Examiner must be notified MD N/A Baltimore 1 Yes 2 No ь 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 4956 Carmine Ave. 21207 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 Married 2 XNo 1 Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black "natural", Completed 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the N/A N/A other traumatic event, Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Edwin Allen III Michelle Hamlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Hamlin-Mother 4956 Carmine Ave. Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 Burial 2 Cremation 3 Removal from State 6/18/2012 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) King Mem. Park March F/H- East 21. Signature Funeral Service Licensee 22. Name and Address of Facility ann 1101 E. North Ave. Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest each line shock, or heart failure. List only one cause nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical r as a consequence of) Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of, the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ ģ Day Month Year the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy pade performed? Yes 2 No After this certificate 1 ☐ Yes 2 ☐ No completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗌 No Other: မ 1 N Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28c. Inju wor 1 28c. Inju wor 28d. Describe how injury occurred 1 Accident 5 Pending Investigation 1 ☐ Yes 2 🛂 No Suicide 6 Could not be 4 Homicide 28f. Location (Street d Number o determined 4956 24 hours a Funeral E Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) Res-000 10 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ex 800 Baltimore Orleans St MO 21287 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ rown ara une Medical give street and number) a. Facility Name (If not institution 4c. Counfy of Death 4b. City. Town, or Location of Death Examiner rince 7. Age (In yrs. last birthday)
Yrs. Security Number If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. (Month, Day (Month, Day Director Usual Residence of Decedent 28a-f show 10b. County 10a State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No emple land theorges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed permit. Page 1 and 2 should be filled within 72 hour Department of health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, PO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1616 Washington Portland AVR Mary land Fort 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State nnandale 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Shirlington Road Virginia 22206 Arlington Rober 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as eardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Physician/ Adenucarcinma disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir sician and burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy Hospital or Attending Physician: The 1 🗌 Yes 2 🗌 No 1 Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Funeral Director: After 1 🔽 Natural injury Natural
Accident 5 Pendina 1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D35206 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1701 LVingim Road, fort WASHingon lim 1 um 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ BOUD ILLIAM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice at Northwest Hospital Randallstown Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Director 214-22-8442 1 🛛 M 2 🗆 F 83 9/16/1928 MD or 28a-f shov or than "naturel", or items 23a or 28a-f sho 10a. State 10b. County death with the Maryland 10c. City, Town or Location Directo 10d. Inside City Limits 1 🗌 Yes 2 🔯 No MD Baltimore Randallstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 10707 Marriottsville Rd. 21133 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 2 1 Never Married 2 K Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 2 No 1 ☐ Yes 2 K No Specify. Completed 3 Widowed 4 Divorced Year or Dates. Unknown Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 Supervisor/Dispatcher <u> Howard</u> Co. 911 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental I ant: If item 27 is marked o Austin Carter Boyd Eva Cecilia Tripplett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) E. Yvonne Boyd/Wife 10707 Marriottsville Rd., Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. 4 Donation 5 Other (Specify) Lake View Mem. Park 7/2/2012 Sykesvillw, MD 21. Signature of Funeral Ser <sup>22</sup> Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. neumo disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir attending physician and for use as the burial-transi Cause (Disease or Lijury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Day Year eral Director: After this certificate has been signed by the a filled in by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 🔲 No Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA after death. 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No. 2 Accident Investigation 3 Suicide ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, To the Hospital of within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Moun 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Deangelo 12-04756 Bess UNKUNK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

IK UNK		State of Maryland / Department of 1- For State Registrar Certificate of		20	12 2082
Physicia edical Exami		Decedent's Name (First, Middle,Last)		Reg. No.  2. Date of Death  Month Day Year	3. Time of Death
edicai Exami	ner		o. City, Town, or Location of Death	June 24, 2012	2000 hrs
		rear of 1000 block of North Central Avenue	Baltimore	NIA	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  2 1 8 - 1 3 - 6 0 3 6 1 M 2 F 2 6 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Mir	Fore	
Any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locatio	n.		10d. Inside City Limits
È.,	ō	md. NA Baction			1 Yes 2 No
death with the Maryland or items 23a or 28a-f show must be notified at ooce.	Director	10e. Street and Number 1205 Washington Blvd	10f. Zip Code 2 1 2 3 0	10g. Citizen of What Co	untry?
leath with r items 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispanic Origin? ( Ss, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.) 14. Race - Ame White, etc.	prican Indian, Black,
e	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Yes 2 No specify: s Usual Occupation (Give kind of	Specify:  Work done 16b. Kind of Business	Slack
5-0036 led within 72 he Hygiene. nther than "n	Completed	12 College (1-4 or 5+) NA Car	st of working life. DO NOT use reti	- 1 -	otire
Dre, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Montal Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-fahe her traumatic event, the Medical Examiner must be notified at occe.	Be	17. Father's Name (First, Middle, Last) Geodified Bess	Angel		
MD 2' 12 should th and Mo 127 is ma umatic e	7			Rural Route Number, City or Town, Stat L. Nottingham, m	
e, Feating Health			on (Name of cemetery,	Date 208. Location - City o	r Town, State
Baltimore, perm t. Pages I ar Department of Hee Impertant: If ite		4 Donation 5 Other Specify: MT. 210	n CEM 6-	30-12 Lansdow	
Baltimo		Signature of Funeral Service Licensee 22. Na	me and Address of Facility 34	of W. Franklin	Striet
Physician		2 Tart I. If ter the disease, or complications that caused the death. Do not enter the failure List only one cause on each line.	mode dying, such as cardiac o	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Gunshot Wounds  Due to (or as a consequence of):			Death
	إ	Sequentially list conditions, b			
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated  C			
and - transit	EX	events resulting in death) Last			
be ex ician	edical	UNPENDED AMENDED			
lox 68760 eath certificate be attending physi	an/M		death 3 Ectopic pregna	23d. Date of deliver mocy Month	y Day Year
B 5 5 B	Physician/M	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Othe	r (Specify)		
ires that the signed by	2	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacco use contribute to 1  Yes 2  No 3  Pro	A STATE OF THE STA
of Vital Records, og Physician: The law require this certificate has been si meral director, page 2 should be	Completed				utopsy findings available completion of cause of
		25. Was case referred to medical	26.Place of Death (Check of	1 Yes 2 No 1 Y	es 2 No
Vital   hysician:	O B	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outoatient	Other -	g Home 5 Residence 6 🗸 Othe	r: Scene
ion of Vital tending Physician; death.  tor: After this certif	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation  28a. Date of Injury  (Month Day Year)  1950 hrs		28d. Describe how injury occurred Subject shot	
Division pital or Attendit ours after death. eral Director: A	Certification:	3 Suicide 6 Could not be determined Could not be determined (Specify) Parking Lot		28f. Location (Street and Number or Ru or Town, State) rear of 1000 block of Central Avenu	
Division of N To the Hospital or Attending Ph. within 24 hours after death. To the Fuceral Director: After it completely filled in by the funeral	edical (	29a. Certifier Check only one)  Certifying Physician: To the best of my knowledge, death occurred one)  Medical Examiner: On the basis of examination and/or investigation and manner stated.	d at the time, date and place, and n, in my opinion, death occurred at	due to the cause(s) and manner as stat t the time, date and place, and due to th	ed. ne cause(s)
	Ž	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mo June 25, 2012	nth, Day, Year)
3	1	30. Name and address of person who completed cause of death (Rem 23a)			
_		Russell Alexander MD. Assistant Medical Examiner 900 W  31. Date filed (Month, Day, Year) 32. Registrar's Signature	Baltimore Street, Baltim	ore, MD 21223	
Sta Registr	_			OCME	

DHMH 17 Rev 1/2001

ORIGINAL

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ane Medical 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Min. Director 1 M 2 F 28a-f show 10b. County 10c. City, Town or Location must be notified at Director Nes 2 □ No TIMO 10g. Citizen of What Country? ò 23a Completed by Funeral permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decede 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Sumarry 17. Father's Name (First, Middle, ပ 19a. Informant's Name/Relationship (Type 9608 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licens Home North 23a. Part -Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ntracerebra hemonhage Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** erten sim Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy cate has been signed by the atterpage 2 should be detached for in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certificate has 1 ☐ Yes 2 ☐ No completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: ပ္ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural 2 Accider injury 5 Pending 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) 29c. License number June 28,2012 ts -000 30. Name and addie erson who completed cause hang State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 5 28 AM EUGENE CAMPBEL 30 JUNE Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death BALTIMORE YA MEDICAL CENTER MORE BAL 8. Date of Birth Birthplace (State or Foreign Country) Age (In vrs. last birthday) Year If Under 24 Hrs. **Funeral** Min -80-952 1 M 2 - F **Director** and 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race -American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College 1 and 2 should be filed within if Health and Mental Hygiene. item 27 is marked other than (1-4 or 5+) Suites-Nerget Home wood Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Oh 19a. Informant's Name/Relationship (Type, Pri 19b. Mailing Address (Street and Number or Rural Ro-te Number, City or Town, State, Zip Code)  $\,$  21133Randalistun or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Methed of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State Mills 4 Donation 5 Other (Specify) rrison fore Wings 21. Signat f Funeral Service Licer Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cauca. Enter Onzenying Cause (Disease or injury Examine Due to (or as a consequence of): and I-transit that the death certificate be executed PANCYTOPENIA that initiated events resulting in death) Last -burialng physician a Physician/Medical LUNG CANCER Box 68760 attending IF FEMALE: nse yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No jo Day Month Year Pregnant at time of death ed by the a detached f 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires MUCOSITIS 2 No 3 Probably 4 Unknown been sig should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 2 No Yes 2 No 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ s after death.

I Director: After this ad in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5  $\square$  Pending work? Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours af

To the Funeral Di

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 1518192368 JUNE 30 2012 Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 SOUTH GREENE STREET. MACKENZIE SHORT BALTIMORE

DHMH 17 Rev 06-2011

Registrar

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32. Registrar's Sign Cure

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		•	For State Registrar			ertificate of L			Reg. No. 2	)   2	20833
	Physicia	n/	1. Decedent's Name (First, Middle, L	•	/			2. Date of De Month	Day	Year	3. Time of Death  7:/2 AM
*****	Medic Examir		4a. Facility Name (if not institution, gi	CHANEY ve street and number)	<u></u>	4b. City, Town, or	r Location of Death	6	4c. County	o/2_ of Death	7:17 AM
	Ladiiii		GOOD SAMARI			BAL	TIMORE				
	Funeral Director		215-28-5295	Sex 1 □ M 2 ★ F	n yrs. last birthday) Yrs.	Months Days	1f Under 24 Hrs. Hours Min.	8. Date of Bii (Month, Da	th ay, Year) 3-1930	9, Birthp Count	place (State or Foreign try)
	and show dat	ō	Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L					11	Od. Inside City Limits
	th the Maryland 3a or 28a-f shov t be notified at	irec	MD		BAU	TIMORE	=				yes 2 ☐ No
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner.	Funeral Director	10e. Street and Number 6608 Birchw	good AVEN	ue	10f. Zip Code 2/2	-14		10g. Citizen of	What Coun	
(0	after death with ", or items 23 caminer must	by Fur	11. Marital Status  1  Never Married 2  Married	12. Was Decedent Eve Armed Forces? 1 Yes 2 No		. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
21215-0036	ural", ( ural", (	ted b	3 ₩Widowed 4 □ Divorced	If Yes, Give Year or Dates.	,	1 🗌 Yes 2 🛣 No	Specify:		Specify	Bla	.cK
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and	atal ed ev	To Be	17. Father's Name (First, Middle, Las				18. Mother's Nam Charlog				
Maryland	2 should be th and Men 7 is marke traumatic		Charles Henry 19a. Informant's Name/Relations ip		19b. Mai	ling Address (Street					ode)
	= 0 -		Karl Russell	Son	258.	3 Cosmos 1	Drive-F	TLANT.	A, GA.	3034	5
Baltimore,	e ± t e		20a. Method of Disposition  1 → Burial 2 □ Cremation 3	Removal from State		ematory or other plac	ce)	Date	20c. Location  BAUTIA		
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ä	an Jack		1305 mo	1553						MO.	21212
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final	one cause on each line.					rrest,		Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	a. Due to (or as a c	CERIG onsequence of):	HT HEAR	RT FAIL	URE		-	
بسب	Examiner	Į.	Sequentially list conditions,			TRUCTIVE	PULMO	NARY	PISEAS	F	
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Box 68760	ath certificate be attending physicia for use as the bur	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Ectopic pregnand	274		23d. Da	te of delive	ery
	9 9 p	ysicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at til 9 Unknown		Other (specify)			Mo	onth	Day Year
P.O.	that the led by detacl	y Ph	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause gi	ven in Part I.	23e. Did t	tobacco use cont	ribute to th	e cause of death?
	law requires that the derinas been signed by the a Should be detached	ted b	MORBID C	BESITY,	ACUTE	KIDNEY	'NJURY	F 1 1 1/2	Yes 2 □ No	3 🗆 Prob	oably 4 🗆 Unknown
Division of Vital Records,	2 38	nple	HYPERTENS	ION , DYS	LIPIPE	MA		24a. Was	psy	Were autop prior to cor death?	osy findings available inpletion of cause of
- Re	The ate	o Co	25. Was case referred to medical			26 PI	lace of Death (Chec	1 🗌 Yes	2 No	1 Yes	2 🗆 No
Vita	Physician: this certific al director,	To Be	examiner? 1 X Yes 2 No	Hospital: 1 Inpatient	: 2 ☐ ER/Outpati	Oth	er.		dence 6 Oth	er (Specify)	
n of	De fe d	ate:	27. Manner of Death  1 Natural 5 Pending	28a. Date of injury (Month, Day, Y	(ear) 28b. Time injury	work		28d. Describe	how injury occurr	red	
isio	Attenost deat ector: by the	Certificate:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be 28e. Place of Injury			res 2 🗆 No		Street and Numb	er or Rural	Route Number,
<u>S</u>	urs after or real Dir			building, etc. (				City or To			
	e Hosp 124 ho e Fune bleted f	Medical	(Check 2 Medical Exa	nysician: To the best of my miner: On the basis of exar frse Practioner: To the be	mination and/or inve	estigation, in my opinio	on, death occurred a	t the time, date	and place, and du	e to the cau	ise(s) and manner stated.
_	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu	-	29b, Signature and title of certifier	19-	,	29c. License	e number		29d. Date signe	d (Month, E	Day, Year)
	(h)		30. Name and address of serson wh	o completed source of de-	th (Itam 22a) (Tire-		=S 000		6/1.	3/20	12
	(1)		SUNGRYONG			OCH RAVE	N BLVD	BALT	MORE	212	39
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist ar's		boas					

to ME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20834 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June Physician/ Barbara 2017 2353 Ducasse Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Randallstom NMhwen Hospital Baltmore If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Months **Director** amaica Usual Residence of Decedent show Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2120 50 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. δ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Şeconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဥ 19a. Informant's Name/Relationship (T pe, Print) 19b. Mailing Address (Street and Number Rural Route Number, City\_or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Fugeral Services 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiogenic Physician/ Shock disease or condition resulting in death) Medical Due to (or as a lo sequence of) **Examiner** IEAVS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year 4 Pregnant 9 Unknown Pregnant at time of death 1 L Yes 2 L 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ျှ 1 Yes 2 X No 1 Inpatient 2 R/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) June 26,2012 D723217 who completed cause of death (Item 23a) (Type, Print)
, Mp 540 old Cmm4 Randallston, MD 21133 Rond

State Registrar 32. Registrars Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 2012 Physician/ Fick 05:08 AM June Sadie Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel Pasadena 7843 Bodkin View Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number **Funeral** Months Dec. 08 1 □ M 2 💢 F Hours ື1919 MD 217-18-0526 92 **Director** Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Director Pasadena 1 Yes 2 X No Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ō ms 23a or must be r USA Funeral 21122 7843 Bodkin View Drive items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 14 Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status "natural", or iten edical Examiner Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates. al Hygiene. d other than "natura event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Household Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F Unknown Kate Rothhaupt Frank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 she Department of Health an Important: If item 27 is any injury or other trau once. 7843 Bodkin View Drive, Pasadena, MD 21122 Pamela Swaggerty (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June Date 30 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, Maryland Glen Haven Cemetery 2012 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> the opati. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Cardiovasular disease Hypertensive arteriosclerotic Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): resulting in death) Last as the burial-Physician/Medical P.O. Box 68760 IE EEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Failure to thrive, Hxparoxysmal atrial Fibrillation 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of Hx Deep venous Thrombosis Hx duodenal wicer 24a. Was an autopsy performed? Yes 2 No death? DiAbetes Mellitus type 2 HX RECURRENT URINARY INFECTIONS 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Certificate: 27. Manner of Death After 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar

To the within 2

only one)

29b. Signature and title of certific

31. Date filed (Month, Pay, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIA MARTINEZ, MD

2932-A

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

37229

MOUNTAIN ROAD PASADENA

29d. Date signed (Month, Day, Year)

06/28/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2012 Matthew Giordano Α. 06:05 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1678 Twickenham Road Pasadena Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth

(Month, Day, 7. Age (In vrs. last hirthday) Birthplace (State or Foreign Country)
 TT **Funeral** Days 1 X M 2 - F Director 94 **"1**"917 NJ Yrs 137-09-6671 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 X No Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1678 Twickenham Road 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 

Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 XWidowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk U.S. Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph Giordano Matilda Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew A. Giordano, Jr. (son) 1678 Twickenham, Pasadena, MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) June 28 Metro Grematory Inc. Baltimore, Maryland 2012 21. Signature Funeral Service License Name and Address of Facility Stallings Funeral Home, P.A. <u>3111 Mountain Road, Pasadena, MD 21122</u> not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part . Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DZONAVLY HEART Medical Due to (or as a consequence of): Examiner Sanuantially list envirtitions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Tes 2 **N**o ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Sesidence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deal Funeral Director Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled n by 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date

nd address of person who completed cause of death (Item 23a) (Type, Print)

EAN HAR

D0010456

MAGOTHY BEACH RD PASADEMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06:10 AM 2012 tim Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Deat Examiner 4c. County of Death Medical Merzy 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) SC **Funeral** (Month, Day, ) 1 □ M 2 🔀 F Days Hours Min. 8 / Yrs. 215-28-2399 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore MD Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33rd ST 1050 E. USA 21218 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ ☐ Yes 2 ☑ No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 Wo BLACK 3 Widowed 4 ☐ Divorced Specify: Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bugle Laundry Elementary/Seconday (0-12) College (1-4 or 5+) aunderer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) oxanna Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis (DAUghter) TWILLGHT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State GARCISON FIREST BatTIMORE, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugha Greene Finerar Sers 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician 9 Tah (all cer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death signed by the a ld be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Ionine investigation within 24 hours after death.

To the Funeral Director; After this certificate Income and the funeral director, pag 2 🗆 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 🗌 Yes No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 2012 d address of pe rauelte Mazarian. 301 ST. Rwi ST odical

State Registrar (Month, Day, Yea

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 23 2012 5:45AM M June Richard Lease Holtzople Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Walkersville Glade Valley Nursing & Rehab Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Director 213-20-5162 1 🛛 M 2 🗆 F 93 Aug. 12, 1918 Maryland Usual Residence of Dece 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Examiner must be notified at **Funeral Director** 1 XYes 2 No Walkersville Maryland | Frederick or 10f. Zip Code 10g. Citizen of What Country? 23a with USA 21793 9923 Kelly Rd. "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 X No Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 Petroleum Products Owner/operator/distributor Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Sumame) ည Zelma Lease traumatic Clinton Holtzople 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Walkersville, MD 21793 9923 Kelly Rd. Betty Holtzople/wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State All County Cremation June 30,2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Econsec 22. Name and Address of Facility Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Myscardial disease or condition Medical resulting in death) Due to for as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last Physician/Medical phys the b Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth 2 ☐ Fetal down ☐ Pregnant at time of death in the past 12 months? Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred : After 1 🗷 Natural 5 Pending injury in 24 hours after deam.

The Funeral Director: Aff

""" in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying turse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sol Town

32. Registrar's Signature

31. Date filed (Month, Day, Year) **JUL 0 2 2012** 

D43091

6-29-12

House Ave, Frederick MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ '0:10pm IaRi june Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner NA ama red a If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 212-34-4146 Hours Min (Month, Day, Year) 1 - M 2 - E Director March 17 1939 land or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a rose Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black White etc. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. δ Never Married 2 Married 1 ☐ Yes 2 ☐ No Completed 3 - Widowed 4 - Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) La 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) woodraw withon Dr. Herndon **Baltimore**, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Dogation 5 ☐ Other (Specify) 3,2012 Tus Six ire of Funeral Service Licensee md, 21229 disease, or complications that caused the death. Do not enter the mode Approximate ck, or har faile Immediate Caus (Final failure. List only one cause on each line. Interval Between Onset and Death Physician/ disease or condition resulting in death) av Medical s a consequence of Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial Physician/Medical P.O. Box 68760 use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Other (specify) the g Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 **N**lo 3 ☐ Probably 4 ☐ Unknown Completed need 24a. Was an 24b. Were autopsy findings available prior to completion of cause of e Hospital or Attending Physician; The law 1 24 hours after death. e Funeral Director; After this certificate has b page 2 s autopsy perform death? 1 Tyes Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 4 Nursing Home 5 Residence 6 Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the within 7 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Type, Print)
Edward Seclel MID; 5601 Fock Kaven Blvd, Baltimore, Mary king Edward Seilel MD Registrar

AMEND #25 PER ME G928 6/28/12 TRT State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HAYNES 8-45A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Director 214-74-7745 1 DM 2 DF 56 AUG 15. 1955 Maryland Usual Residence of Deced 28a-f show notified at 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carrol1 Westminster 1 ☐ Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a 21157 Funeral 69 John Street items 2 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Medical Examiner Black, White, etc. P. 1 Never Married 2 XMarried ģ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the 11 Mechanic Automobile Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Should be Department of Health and Menta Important if item 27 is marked any injury or other traumation ဂ္ Lawrence W. Haynes Louise Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 69 John Street Westminster, MD 21157 Bonnie S. Havnes/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State All County Cremation Services 6/21/2012 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License P.O. Box 195 Sykesville, MD 21784 (410-795-1400)23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Massive -1- Bleed upper disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) death certificate be executed and burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? be detached for Month Year Day Pregnant at time of death 2 No 9 Unknown 9 Unknown that the P.O. à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Hemmahagi-c Shock Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed? 1 Yes 2 No Yes 2 No Physician: director. 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Hospital Other: 1 X Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending 1 Natural
2 Accider
3 Suicide work?
1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 5 Pending injury Division Accident Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check Certifying Nurse Prantitioners to the best of my knowledge; deat urrad at the three date and place, and due to the cause(s) and mainter as state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/19/12 039502 43 1000 and address of person who completed cause of death (Item 23a) (Type, Print) 447, East Main st Westwinster My 21157 Hacain h:1 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Baltimore,	~ U - L	Ĺ	1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		cem	etery, crem	sition (Name of patory or other place		Date		ocation - City		
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Visi	r Atterder de irecto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could detern		28e. Place buildii	of Injury	- At home	e, farm, stre	et, facto	y, office				Street an	d Numbe		Route Number,
Ö	Hospital or 24 hours afte Funeral Dir			<b>S</b> 4		HOME								BALTIM	ORE,	MD		MAR AVENUE
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	Star Registra		31. Date filed (Month	n, Day, Year)		32. R	egistrar's	Signature	9									
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DHMH 17 Rev 7/2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JULY <u> Annalee</u> Lucretta Medical Mullenax 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BURNE BALTIMORE WAKHINGTON MEDICAL ANNE CHEM CATTER. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday If Under Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 232-38-6345 Director 1 □ M 2 🔀 F 85 Yrs. 11 1927 May WV Usual Residence of Decede or 28a-f show notified at 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2X No Brooklyn Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 602 Hammonds Lane, Apt 305 USA 21225 MULLENAY, ANNALEE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: White Specify: 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygier is marked other t Household Homemaker other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Canan Slaubaugh Reddie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Robert W. Mullenax 602 Hammonds Lane, Apt 305, Brooklyn Pk., MD 21225 (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 05 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem 2012 Crownsville, Maryland f Funeral Service Louise 21. Signat re 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. 23a. Part 1. Enter the dis shock, or heart failu se, or comp List only or Approximate 25.5 Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to lor as a conse, lience of thany wading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Examir The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buris Physician/Medical P.O. Box 68760 IF FEMALE: IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 month Month Day 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page ; performed Yes 2 certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🖺 Yes 2 No မ ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer injury Accident 5 Pending 1 Tyes 2 🗌 No within 24 hours after death. To the Funeral Director: A Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 $\square$ Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Date signed (Month, Day, Year) 30. Name and address of person who complete we Glen Burnie mits

State Registrar 31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Year Lee Moore, Jr. 19:09 PM JUNE 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Deat SINAI HUSPITAL BALTIMORE CITY N OF BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Mgnth, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) 214.62.9034 Director 1 M 2 D F MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the <u>Medical Examiner must be notified at once.</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Country Court Apt. As 21208 7207 Valley USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by African 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced American 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) VA Medical Center 12th grade 2 years Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Lee Moore Willie Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Moore Mar-Mar Lane Navarre Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/06/2012 Baltimore, MD On-Site Cremation Center 22. Name and Address of Facility C. Greene Funeral Services 21. Signature of Funeral Service Licensee Jaughn Vaus Randallstown MD21133 Koad 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. ahent Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ISCHEMIC CARDIOMYOPATHY disease or condition > 2 years Medical resulting in death) Due to (or as a consequence of) Examiner months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and ched for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed CARNIAC 80100 hours that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery After this certificate has been signed by the atter funeral director, page 2 should be detached for in the past 12 months? Month Day 1 Yes 2 Unknown Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown ventricular tachycardia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy After this certificate To Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 14 Natural 5 🗌 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fu 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MBBS PAS-018013 JUNE 27, 2012. 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALHOTRA , MBBS, SINAL HOSPITAL OF BALTIMORE 31. Date filed (Month, Day, Year)

JUL 0 2 2012 32. Registar's Signature State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 24, 2010 Luke Mitchell, Jr. 12:48 P 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Civista Medical Center Charles LaPlata If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours Director 578-70-9625 1 M 2 - F 59 04/25/1953 Washington, DC Usual Residence of Decede 28a-f show Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director Charles Waldorf 1 XYes 2 No MD ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 20602 USA 816 Copley Avenue items 2 death \ 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or ð 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 🗆 Widowed 4 🔀 Divorced Completed Black Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Church PhD Pastor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever P Luke Mitchell, Sr. Fannie Mae Simmons Department of Health and Important: If item 27 is n any injury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 816 Copley Avenue; Waldorf, MD 20602 Lukisha D. Mitchell, Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date \*\*Burial 2 Cremation 3 Removal from State Bethelham BC Cem. 7/8/2012 Edgefield, S.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Physician/ Onset and Death 5 vears disease or condition resulting in death) Hepatic Failure Medical Due to (or as a consequence of) Examiner 35 years Chronic Active Hepatitis C Sequentially list conditions, Examine Due to lor as a punisolimite of cause. Enter Underlying Cause (Disease or injury Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Dav Year 1 Yes 2 9 Unknown 2 No Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Type II Diabetes Mellitus, Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Chronic Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 1 Yes 2 No မှု 1 Inpatient 2 XER/Outpatient 3 IDDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death the f 2 Accident
3 Suicide Investigation 6 Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) within 24 hours a Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitionan To the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manner stated. 29a. Certifier (Check

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Registrar DHMH 17 Rev 06-2011

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

hewir um arshy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Lewis Marshall, M.D. 6525 Belcrest Rd. Ste 130; Hyattsville, MD 20782

D0007660

29d. Date signed (Month, Day, Year)

06/25/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 5 35AM 3 8 ay Mcdonalo erru Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Westminster Carroll Hospital Center Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Month Days Min (Month, Day, Year) 213-68-5057 1 □ M 2 F **Director** 57 Jun 14 1955 MD Usual Residence of Deced 28a-f show 10c. City, Town or Location 10a. State 10b Count 10d. Inside City Limits with the Maryland Director notified MD Carrol1 Taneytown 1 X Yes 2 No 10e. Street and Number ms 23a or must be n ō 10f. Zip Code 10g. Citizen of What Country? Funeral 21787 US 164 Carnival Drive items within 72 hours after death "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. Specify 3 Widowed 4 X Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than, life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the M ACS Account Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Hattie Plunkert Jesse Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4108 Teklen Drive, Westminster MD Stephen McDonald - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Good Shepherd Cem Jul 6 2012 Ellicott City, MD 21. Signature of Funeral Service 22. Name and Address of Facility Burrier-Queen Funeral Home 1212 West Old Liberty Road, Winfield, MD 21784 coll 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Adeno Carcinom Physi\_ian/ LV eta disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury Due to (or at a contequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23b. Was decedent pregnant in the past 12 mg/ths? 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year Pregnant at time of death the detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ creheral 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform certificate I 1 ☐ Yes 2 ☑ No 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 10 မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 Yes 2 No Natural 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifie 29b. Signatu

Registrar

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and address of person who

2012

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State

Date

447, East Main Sheet

westwinster HD 21157

pleted cause of death (Item 23a) (Type, Print)

MS

32. Registrar's Signature

Hosain

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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at one.		19a. Informant's N				19b. Mailin	ng Address (St	treet ai	nd Numbe	r or Rura	l Route Numb	er, City o	r Town, Sta	ate, Zip Co	ode)
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39 ×	eath certifica attending pl	an/N	IF FEMALE: 23b. Was decedent in the past 12		23c. If yes, out	tcome of pregna Birth 2  Fet	ancy al death 3	Ectopic preg	nancy					23d. Date	of deliver	•
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 55 am Month 20/9 HELENA MILLER Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner City, Town, or Location of Death MORYland Greneral tal altemore Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Hours 06-10 Pax 1924 217-20-3015 88 Director MD. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE XX Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2004 BRYANT AVENUE 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: BLACK 3 X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) TEACHER EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ESTHER H. MORRIS DOSWELL WILLIAM 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 276 SKYWAY DR., SAN JOSE, CA 95111 ROBERT MILLER/SON 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ARBUTUS MEM PK 7/3/12 BALTIMORE, MD Signature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Buckenial disease or condition resulting in death) Prevnania **Medical** Due to (or as a consequence of): **Examiner** 10000 Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed months Cause (Disease or iinjury , hazda that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an cate has page 2 s performed Yes 2 certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 12 Natural 5 Pending work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fi Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

29b. Signatu

(Check only one)

31. Date filed (Month, Da

3 🗌

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EU

Registrar's Signa

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

043386

HZA Bolhinor

29d. Date signed (Month, Day, Year)

6.29.12

21217

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ O'Neal Month Patrick K. Sr. 5:10а м Medical June 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore Examiner 4b. City, Town, or Location of Death Gilchrist Hospice Center Towson 5. Social Security Number 6 Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Funeral 9. Birthplace (State or Foreign Country) Maryland 212-60-8062 Director 1 X M 2 □ F 56 September 2,1955 Usual Residence of Decedent ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Dundalk Md. 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3458 Dunran Road 21222 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. δ 1 ☐ Never Married 2 🛭 Married Yes 2 No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Hygiene. other than "natural", If Yes, Give White Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maintance Baltimore City 12 years I and 2 should be filed wit f Health and Mental Hygie tem 27 Is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Leo O'Neal Mildred Strom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine O'Neal Wife 3458 Dunran Road, Dundalk, Md. 21222 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 30 20c. Location - City or Town, State permit. Page 1 a Department of I Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 2012 21. Signature of Fundal Service Licenses Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 complications that caused the death Do not enter the mode of dying, such 23a. Part 1. Enter the disease, o complications that caused shock, or heart failure. List only one cause on each line. cardiac or respiratory arrest. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): The law requires that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Month Year been signed by the s should be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 Yes 2 No Yes or Attending Physician: funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Division n 24 hours after death.

e Funeral Director: Aft bletely filled in by the fur 1 ☐ Yes 2 ☐ No Investigation Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Checl 3 🔼 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated hature and title of certifier 29c. License number DO011781 of person who completed cause of death (Item 23a) (Type\_Print) led St. 144105, Baltimore Shaheen 670(N 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#260 & BOHYS G929 17/2/12012 Wental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ ernadine Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death runad Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign Funeral Hours Country) **Director** 1 🗆 M 2 💢 F higton DC is marked other than "natural", or items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location nside City Limits **Funeral Director** Yes 2 No 10g. Citizen of What Country? 10000 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify white 3 Widowed 4 □ Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 100 Be 17. Father's Name (First, Middle, Last) 18. Mother's ne (First, Middle, Maiden Surname 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 20a. Methodic Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of 20c. Location - Ci Town, State Date 21. Similature of Funeral Serv 23a. Part 1. Enter the shock, or head edisease, or complications that caused failure. List only one cause on each line ed the death. Do not enter the mode of dying, such a cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ 0 Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day the Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٤ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
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DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, D

Day, Year) 2012

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30<sup>Day</sup> Physician/ 2012 June 9:46 AM Eleanor Μ. Passarella Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1156 Wharf Drive Pasadena Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Director 216-24-8593 1 ... M 2 🔀 F 83 May 28, 1929 Maryland 28a-f show 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Anne Arundel Pasadena 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1156 Wharf Drive 21122 U.S.A. or items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Examiner Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married Completed by 2 X No Baltimore, Maryland 21215-0036 Yes Specify: White 1 Yes 2 No Specify: If Yes, Give "natural", 3 ☒ Widowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 10 N/A Telephone Operator A T & T Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Stephen Romev **Flizabeth** Fabula Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Anna Maria Watts (Daughter) 8117 Gray Stone Lane Pasadena, Maryland 21122 other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/03/2012 Cremation Glen Burnie. Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00-732 McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phymician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 9 Unknown the Unknown signed by t d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed' death? certificate Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 No Other: ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify, this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death.

the Funeral Director: After in pletely filled in by the funer 1 X Natural 5 Pending work 1 Tes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar Oak Point

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filled (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #25,27,28A-F, PER ME G928 6/18/12 TRT
State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $14:45P_{M}$ 1 9<sup>Day</sup> William Thomas Ray Jr. Physician/ June 2012 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Carroll 4b. City, Town, or Location of Death **Examiner** Carroll Hospice Dove House Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth MD Country) g. Birthplace (State or Foreign **Funeral** Hours 9 - 11 - 1923 88 217-14-9758 1 X M 2 □ F Director show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Carroll Finksburg items 23a or 28a-f s ner must be notified MD 1 Yes 2 No 10g. Citiz. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21048 Funeral 106 Lassiter Circle 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or itel Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Postal Employee Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Gaffeliah Troyer မ William Thomas Ray Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. 106 Lassiter Circle, Finksburg, MD 21048 Gladys A. Ray-wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State South Carroll Crem 6/20/12 Winfield, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Fletcher Funeral Home . Signature of Funeral Service Licensee 254 E. Main St., Westminster, MD 21157 Z Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. NTRACRAMAL Immediate Cause (Final Onset and Death HEMORRHAGE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to for as a consequence of it any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDICAL EXAMINER Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ate has t Yes 2 funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Fother (Specify) N7411 (TN 2 1X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2x No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: SUBJECT PULLED DOWN STEPS BY DOG injury -1- P Natural 5 Pending 24 hours after decth. Funeral Director Ab 6/18/2012 2 Accident 3 Suicide **UNKNOWN**<sup>M</sup> Investigation th 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 106 LASSITER CIRCLE 4 Homicide þ determined filled in FINKSBURG, MD HOME Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur nd title of certifier 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , FlAVIO Westminster, en 31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2=40PM JUN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Baltimore 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 215-34-8011 Director 1 - M 2 X F 28a-f show 10c. City, Town or Location 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director MD Baltimore 1 XYes 2 ☐ No or, 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral Darley USA Avenue 21213 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces . or Black White etc. 1 Never Married 2 Married Completed by 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give is marked other than "natural", 3 Divorced BLack Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Private Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Patrick Kelly 19a. Informant's Name/Relationship (Tv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Balto. Tat Husband adell MO. 21213 Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee Greene Funeral Sus MO158 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to ( as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Dav Year 1 Yes 2 L 9 Unknown Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performe Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 Mo Other: ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending s after death. 1 Yes 2 🗌 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:00 AM 2010 Medical 4a. Facility Name (if not institution, give street and number) County of Death Examiner Rehab & Nursing ( 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Age (In vrs. last hirthday) **Funeral Director** 1 □ M 2 🕑 or 28a-f show at 10b. County 10c. City, Town or Location Funeral Director Baltinone Examiner must be notified 1 Yes 2 No 10g. Citizen of What Country 23a 5 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 Yes 2 100 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) traumatic event, the WAITRESS permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumations. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 419 110/14 SEVERNA 20b. Place of Disposition (Name of cemetery, crematory or other place)

ST STANISIACIS 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility And Rows K. Foheral Service Lice 21. Signature of 23a Part 1/Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ EMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Gause (Disease or injury that initiated events Due to (or as a consequence of) the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? detached for Month Day Year Pregnant at time of death Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed I or Attending Physician: The after death.

Director: After this certificate It 2 🗌 No filled in by the funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Homicide To the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one Signature and title of certifie JUNE 30, 2012 D0060560

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

STEMMERS

RUN

ESLEXIMO -21221

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

617

KHETERAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ WILLIAMS JANET 04:31M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4 DUENTIST WASHINGTON HOSP MONTGOMER 14 KUMA PARK If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Hours 1 □ M 2 💢 F Director or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits Director BLADENSBURG 1 Yes 2 No 10g. Citizen of What Country? Funeral 20710 USA 5203 NEWTON STREET permit. Page 1 and 2 should be filed within 72 hours after death w Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK Specify 3 ₩ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) CIUVERNMENT RECREPATION SPECIALIST 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HORTON WILLIAM WILMA TEAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RYSTAL Williams 5203 NEWTON ST. DAUGHTER #TZ; BLADENSBURG, 40 20110 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 7-6-2012 CANDOVER, MD HARMONU MEMORIALPK 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee BIANCHI 20011 M01257 814 UPSHUR ST MU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final 0 BSI Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner nd S disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) 10 in the past 12 months? Month Year Pregnant at time of death Unknown Day been signed by the should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death?
1 ☐ Yes 2 ☐ No this certificate I 1 Yes After this certification, I 26. Place of Death (Check only one) Be 25. Was case referred to medical 2 40 Hospital 1 🗌 Yes 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending death. 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after dear To the Funeral Director, of completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06-27-12 00 , MO JA HMINA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Altm co 31 BLVD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 29d per doc g929 7-10-12 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Dorothy Jean Weddle 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel 8394 Country Life Road Pasadena 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth If Under 24 **Funeral** Social Security Numbe (Month, Day, 1 🗆 M 2 🟋 Months Days Hours Min 81 Yrs **Director** 186-24-8138 June Usual Residence of Decedent 28a-f shov 10b. County 10a, State notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Pasadena Maryland Anne Arundel ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 8394 Country Life Road 21122 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Should be filed with hand Mental Hygien 7 is marked other to Household 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ other traumatic Erma A. Keckler Cook Department of Health and Important: If item 27 is n. any injury or other traumance. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles A. Weddle 8394 Country Life Road, Pasadena, MD 21122 (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Hill Cemetery July ຶ01 Waynesboro, Pennsylvania <u> 2012</u> Stallings Funeral Home, P.A. 21. Signature of Funeral Service Lice 22. Name and Address of Facility 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death NG CAN Immediate Cause (Final NON SMALL COLL Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of, If any leduling to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and I-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a Physician/Medical O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregrant in the past 12 months? 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month 1 Yes 2 No Month Day 1 Yes 2 9 Unknown ate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 Tyes ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year) aus 6-28-12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 80028 RITCHLE HWY State Registrar

326		Please Type or Print in Black Indelible Ink. Ensure All Copies	Are Legible.	2085
Wilson		State of Maryland / Department of Health and Mental Hyg  1- For State Certificate of Death  Registrar	Reg. No.	
Physicia al Exami	an/	1. Decedent's Name (First, Middle, Last)	Date of Death Month Day Year June 27, 2012  3. Time of 1058	
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  8altimore	4c. County of Death	
uneral Director		Months Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birthplace (Sta Foreign Country)	
d now any se.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Ballinore		e City Limits
eath with the Maryland items 23a or 28a-f show ust be notified at ooce.	Director	10e. Street and Neighber  38/1 (1) orchester Road 21015	10g. Citizen of What Country?	
2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other thao "oatural", or items 23s or 28s-f shumatic event, the Medical Examiner must be notified at 00cc	L	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11 Yes specify Cuban, Mexican, Puerto Ri 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify: or Decedent of Hispanic Origin?) (Specify: o	ican, etc.) White, etc. Specify: Black	Black,
thin 72 hours are. thao "oatura edical Exami	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College Profession  College Profession	rk done 16b. Kind of Business/Industry or Education	1
uld be filed within 7. Mental Hygiene. marked other thao	Be	Oscar Black Hazel	First, Middle, Maiden Surname)  Wir / SUN  sel Baute Number, City or Town State, Zin Code	
D to B E	2	Lisa Tait Daughter 38/1/ Durchester / 20a. Method of Disposition (Name of cemetery, 100)	(1) / 5 // 4	02181
permit. Pages 1 a Department of He Important: If its injury or other t		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: 21 Signature of Funeral Service Licensee  22 Name and A. dr. ss of Facility Value	3-2012 Baltimore 1	no Isero
n ᇍద 트 III hysician	8_0	23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as lardiac or n	respiratory arrest, shock, or heart Approximately	mate Interv n Onset an
/Medical xaminer		failure Lest only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cardiovascular Disease  Due to (or as a consequence of):		Death
	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated cause, under some conditions of the conditions of t		
executed ian and ial - transit	lical Ex	events resulting in death) Last  d.  UNPENDED  AMENDED		<u> </u>
To the Hospital or Attending Physiciao: The law requires that the death certificate be execute within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran	Physician/Medical	23c. If yes, outcome of pregnancy   1	23d. Date of delivery  Cy Month Day	Year
res that the des signed by the a be detached fo	d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Diabetes Mellitus	23e. Did tobacco use contribute to the cause  1 Yes 2 No 3 Probably 4	Unknowr
The law requi cate has been page 2 should	Completed			
Physiciao: ter this certifi eral director,	To Be	1 Yes 2 No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 2	nly one)  Home 5 Residence 6 ✓ Other: Scene 28d. Describe how injury occurred	
I or Attending after death.  Director: Af in by the fun	Certification:	3 Suicide 6 Could not be	28f. Location (Street and Number or Rural Route or Town, State)	Number, Ci
To the Hospital within 24 hours a To the Fuoeral I completely filled	Medical Cerl	4 Homicide determined (Specify)  29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)	)
S W	Med	29b. Signature and title of certifier  O.C.M.E.	29d. Date signed (Month, Day, Y June 29, 2012	
		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio M.D., Ph. D. Assistant Medical Examiner 900 W. Baltimore Street, Baltim	ore, MD 21223	
	1000	31. Date filed (Month, Day Year) 32. Registrary Signature 32. Registrary Signature 33.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Month Elwood L. Wheeler June 30 7:05 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Goodwill Retirement Community Grantsville Garrett Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1**X**XM 2 □ F Days July 19, 1917 Country) Maryland 94 **Director** 216-18-3012 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 🏋 o MD Garrett Accident 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 896 Collier Rd. 21520 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after 1 Yes XX No Specify: "natural", 3XXWidowed 4 ☐ Divorced Completed Specify: White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Engineer Bendix Aviation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clarence Wheeler Clara M. Mielke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Carol L. Porter /Daughter 896 Collier Rd. Accident, MD 21520 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or oth 20c. Location - City or Town, State cemetery crematory or other place)
AII Saints
Cemetery XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Reisterstown, MD 7/3/12 21. Signatur of un Service Lices 22. Name and Address of FacilitEckhardt Funeral Chapel, P.A. 11605 Reisterstown Rd. Owings Mills, MD21111 hele 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of reach line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** scular Mesons 0 Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Cause (Disease or ii that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year 2 No Unknown 9 Unknown been signed by should be detact Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? 25. Was case referred to medical exampler?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Çertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) July 1, 2012 of person who completed cause of death (Item 23a) (Type, Print) Robin Bissell, M.D. 124 Miller St. Grantsville, MD 21536

State Registrar 31. Date filed (Month, Bay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AKA: Betty Jean Carver Day Year Physician/ Month Elizabeth Carver Zdunczyk 3:40P<sup>M</sup> 2012 Medical Zdunczyk June 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 479 New York Avenue Arundel Pasadena Anne If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Ye Days Hours Year 1 □ M 2 😾 F Director 214-26-7986 Nov. 80 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 479 New York Avenue 21122 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify. white 3 Widowed 4 ☐ Divorced Specify: Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AA Co. Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Burkett Carver Georgie Crane L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita Snyder - daughter 479 New York Avenue, Pasadena, MD 21122 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Glen Haven Cemetery June 29,2012 Glen Burnie, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Stallings Funeral Home, PA 3111 Mountain Rd., Pasadena, MD 21122 23a. Part (I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on the line. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between set and Death Immediate Cause (Final 8 Priysician/ disease or condition Medical resulting in death) Examiner cuantially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 1 Yes 2 Unknown should be detached 9 | Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page 2 1 ☐ Yes 2 ☐ No Yes 26. Place of Death (Check only one) 25. Was case referred to medical completed filled in by the funeral director, Be examiner? Hospital 2/X No Other: ᇛ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of s after death. Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature License number and address of person who completed cause of death (Item 20a) (Type, Print) 6934 AVITTION MENI.7 31. Date filed (Monti State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Physician/ Year June Allan Anderson Robert 3:35 p.m. Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Hours 07/23/1930 New York Director 121-24-3868 81 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Box Elder SD Pennington 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 514 Americas Way, #1192 57719 or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: and Mental Hygiene. 3 Divorced 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Mechanical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vincent Anderson Selma Larson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 514 Americas Way, #1192, Box Elder, SD 57719 Dawn E. Alwood/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ott cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Cre 06/04/2012 | Charlotte Hall, MD 4 Donation 5 Other (Specify) . Signature of Juneral Service Lice see 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, 20650 22955 Hollywood Road, Leonardtown, MD Jr. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner UMONIT Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of has autopsy page performe death? certificate | 2 12 N 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred After t 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: of the form 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State, Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

31. Date filed (Mo)

MARYS

HOSPITAL LEOWNRDTOWN MI

		Please	Type or Print i				•	0	ible.	
		For State	State of Maryla				Mental Hy	/giene		
		Registrar  1. Decedent's Name (First, Middle, Last	-1	Cer	tificate of L	Death	1 0 P-1(P	Reg. No. 2	112, 2086	
Physicia		CLAUDIA CAROL	ANDERSON				2. Date of De Month JUNE		3. Time of Death 13:16 p M	
Medio Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	r Location of Dea		4c. County		
	٠.	Southern Maryland			Clint				e Georges	
Funeral		Social Security Number     6. Se	3-11-7	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth a <i>y</i> , <i>Y</i> ea <i>r</i> )	Birthplace (State or Foreign Country)	
Director		578-58-2879 Usual Residence of Decedent	□ M 2 🔼 F 67	Yrs.				7, 1944	DC	
and show	tor	10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits	
Mary 28a-f otifie	irec	MD Prince G	eorges S			1 ☐ Yes 2 🛣 No				
th the	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of What Countr		
ath wi	Funeral Director	6506 Clayton Lane	Dr.  12. Was Decedent Ever in	118 113 1	20746		Specify Yes or No	USA	e - American Indian,	
er dez or ite miner	by F	1 🛣 Never Married 2 🗆 Married	Armed Forces? 1 ☐ Yes 2 💆 No	- 1	Vas Decedent of H f Yes, specify Cuba		to Rican, etc.)	Black	k, White, etc.	
ural", ural",		3 - Widowed 4 - Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🔀 No	Specify:		Specify:	Black	
72 hou "nat edica	Completed	15. Decedent's Ed (Specify only highest gra		(Give I	lent's Usual Occup	during most of wo	orking	16b. Kind of Bu	siness/Industry	
ithin iene.	Con	Elementary/Secondary (0-12)	College (1-4 or 5+) 2 yrs	Chief	of Inter	pretati	Educatio	h Nationa	1 Park Service	
illed wall Hyg	Be	17. Father's Name (First, Middle, Last)		1011201				, Maiden Surname,		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	인	Claude Anderson				Helen :	Pritchet	t		
shoul and l		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Street			er, City or Town, St		
and 2 Health em 27 ther to		Katrina L. Robert 20a. Method of Disposition			Skyline	Dr. Su		MD. 2074		
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Depar Impo any ir		Victoriue	C. Words					ne of Mar		
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the d	eath. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between	
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a	1 ym 1	homa				Onset and Death	
Examiner		resulting in death)	Due to (or as a cons	equence of):						
	ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a cons	equence of):						
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executed ian and urial-trans	_	resulting in death) Last	Due to (or as a cons	equence of):						
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s that gned be de	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	ven in Part I.		mark or a	bute to the cause of death?	
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law r has b je 2 sl	mple						24a. Was	psy p	Vere autopsy findings available rior to completion of cause of eath?	
sician: The law r certificate has b lirector, page 2 s		25. Was case referred to medical			00 PI	ace of Death (Che	1 🗆 Yes		Yes 2 No	
Physician: Trthis certifica	To Be	evaminer?	lospital:	☐ ER/Outpatien	Oth	er.		idence 6 🗆 Othe	r Rossiful	
ig Phy ter thi		27. Manner of Death	28a. Date of injury (Month, Day, Year,	28b. Time of	28c. Injury	y at		how injury occurre		
eath. or: Aff the fu	fica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be		, , , , , , , , , , , , , , , , , , , ,		Yes 2 No				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu	Certificate:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe		eet, factory, office			Street and Number wn, State)	r or Rural Route Number,	
spital		29a. Certifier 1 Certifying Phys	ician: To the best of my kn	owledge, death o	occurred at the time	e, date and place	and due to the o	ause(s) and manne	er as stated.	
n 24 h	Medical	(Check 2   Medical Examin	ner: On the basis of examina e Practitioner: To the best	ation and/or invest	igation, in my opinio	on, death occurred	I at the time, date	and place, and due	to the cause(s) and manner stated	
To the within to the complete	~	29b. Signature and title of certifier			29c. License				(Month, Day, Year)	
00		JANIKONN	U N.(	>	DO	5473	5 /	6/11	112	
00		30. Name and address of person who co	ompleted cause of death (I				000	11.10	and name	
41		DUCINGOL DO	UNDUNING	100	3511	+4011	5 M	Till !	mind 2073	

DHMH 17 Rev 06-2011

Registrar

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760	ospital or Attending Physician: The law requires that the death certificate be executed hours after death.	

<b>1</b> State of Maryland / Department of Health and Menta State Registrar  State of Maryland / Department of Health and Menta Certificate of Death	20	12 2086
	e of Death Day 200	3. Time of Death 3. 3. 4AM
Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of D	
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date	e of Birth 9.	Birthplace (State or Foreign
Director 578-42-8585 1 🗵 M 2 🗆 F 78 Yrs Months Days Hours Min. Min.	nth, Day, Year) 17, 1934	Country) PA
Usual Residence of Decedent May 10a. State 10b. County 10c. City, Town or Location	17, 1954	10d. Inside City Limits
MD Prince Georges Temple Hills  10c. City, Town or Location		1 ☐ Yes 2X No
10e. Street and Number	10g. Citizen of What	Country?
4305 Ranger Ave.  20748  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes	USA	
Armed Forces?  1 Never Married 2 Married   1 Marked   1	tc.) 14. Race - A Black, W	merican Indian, hite, etc.
3 Widowed 4 Divorced If Yes, Give Vietnam 1 Yes 2 🕅 No Specify:	Specify:	Black
3 Widowed 4 Divorced Year or Dates.  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  5+  Attorney	16b. Kind of Busine	ss/Industry
Elementary/Secondary (0-12)  College (1-4 or 5+)  S+  Attorney	Federal G	overnment
Pohort Archer  17. Father's Name (First, Middle, Last) Pohort Archer  Cecelia Fie	*	
Robert Archer   Cecelia Fie		
19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route  2 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	Number, City or Town, State, Hills,Md 207	
20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City	
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Metropolitan Crematory 6-21-20	12 Alexandri	a, VA
The politic process and proces	Home of Mary	land
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respir.	:1nad, MD 2074 tory arrest,	Approximate
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Coronary Artery Disease		Interval Between Onset and Death
Medical resulting in death)  Due to (or as a consequence of):		
Atherosclerosis		
. In the Control of t		
Cause. (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
JEFEMALE:  23c. If yes, outcome of pregnancy  in the past 12 months?  1   Live Birth 2   Fetal death   3   Ectopic pregnancy  1   Very 2   New Second   4   Pregnant at time of death   5   Other (specify)		_
FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	23d. Date of	deliver
Section   Control   Cont	Month	Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  End Stage Renal Disease    Cardiovas acular Disease   Cardiovas		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23. End Stage Renal Disease  Hypertensive Cardiovascular Disease  1. Stage Renal Disease  24. Hypertensive Cardiovascular Disease  25. Was case referred to medical examiner? 1	Did tobacco use contribute  1 ☐ Yes 2 ☑ No 3 ☐	
End Stage Renal Disease  Hypertensive Cardiovascular Disease  24	a. Was an 24b. Were	autopsy findings available
and at the hase so the state of	autopsy prior t performed? death	o completion of cause of
25. Was case referred to medical examiner?		res 2 🗆 NO
Hospital: 1 Inpatient 2 ER/Outpatient 3 DoA Other: 4 Nursing Home 5 E	Residence 6 Other (Sp	ecify)
28d. Detection   28d	cribe how injury occurred	
28d. Detection of Death  1 X Natural 5 Pending 1 Accident Investigation 3 Suicide 6 Could not be determined 1 Death 1 Death 1 Death 2 Death 2 Death 3	ation (Street and Number or F or Town, State)	Rural Route Number,
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Loc City  28g. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28g. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28g. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		·
Hypertensive Cardiovascular Disease    Hypertensive Cardiovascular Disease   24   1   1   1   1   1   1   1   1   1	date and place, and due to the	e cause(s) and manner stated
29b. Signifure and title of certifier  29c. License number	29d. Date signed (Mor	nth, Day, Year)
1 Metreo TS4 mo MD 5672	6.14.	/2
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Prafufula Mehrotra, MD 4100A Georgia Ave NW Washington	DC	
Prafufula Mehrotra, MD 4100A Georgia Ave NW Washington State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	, ,,	

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend #19a Per INF G929 //13/2012 Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2012 Physician/ June 17, Hakan Buyukcan 6:58 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Montgomery Hospice Montgomery Rockville If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Hours 216-41-8460 **Director** 1 X M 2 🗆 F 43 Jan. 31, 1969 Turkey Usual Residence of Deced or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any pine. 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Maryland Montgomery Gaithersburg 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 18502 Sweet Autumn Drive #304 Turkey 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☒ No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gulten Buyukcan Ibrahim Buyukcan 19a Informant's Name/Relationship (Voa Print Sharon Buyukcan (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ister) 18502 Sweet Autumn Dr. #304 Gaithersburg, MD 20879 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X BuriaL 2 Cremation 3 Removal from State Adana Cemetery 6/20/2012 5 Other (Specify) Adana, Turkey 4 Donation 22. Name and Address of Facility Metropolitan Funeral Service 5517 Vine St., Alexandria, VA 22310 21. Sign, ture of Fineral Service Lix nsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Metastatic Pancreatic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury as the burial-trar and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use a 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery detached for in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 L g Unknown the q 🗌 Unknown been signed by I should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available 24 hours after death.

Funeral Director: After this certificate has etely filled in by the funeral director, page 2 autopsy performed? Yes 2 X No prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 🗓 Other (Specify) Hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 X Natural (Month, Day, Year) 5 Pending injury ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completely filled in by determined Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one)

Registrar DHMH 17 Rev 06-2011 29b. Signature and title of certifie

31. Date filed (Month, Day, JUN 1 82012

donh

Bindu Joseph, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D0060634

6001 Muncaster Mill Rd., Rockville, MD 20855

29d. Date signed (Month, Day, Year)

June 17, 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2012 Year Physician/ Dorothy Curlis 6. 4:45aM Bailey June Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 11750 Asbury Circle Calvert #237 Solomons . Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Davs Hours Director 445-12-6245 1 M 2 X F 87 09/09/1924 Kansas Usual Residence of Decedent Show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 XNo Calvert Solomons MD the 10e. Street and Numbe 10f. Zip Code 5 10a. Citizen of What Country? Funeral 23a 20688 United States 11750 Asbury Circle #237 death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. traumatic event, the Medical Examiner Black, White, etc. 0 þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. "natural", Specify: White 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+ Civil Service Clerk 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) nd Mental I ပ Frank Curlis Leona Oden and is 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health 47847 Molls Cove Lane St. Inigoes, MD Linda Martin / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State Trinity Memorial Cem. 06/11/2012 Waldorf, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sig threat n rat Syrvice Crensee

Edward N. Brinsfield 22. Name and Address of Facility Brinsfield Funeral Home 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Years Physician/ Complications of Diabetes Mellitus Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical certificate be as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Previous stroke, hypertension Hospital or Attending Physician: The law requires 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Director: After this certificate has performed? Yes 2 X No death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No 1 \( \text{Yes} Other: ၉ 4 Nursing Home 5 K Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after 24 hours

To the within 2

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

Division of Vital

John H. Weigel, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Rd. Suite 310 Prince Frederick, MD Registrar's Sign

State Registrar

Medical

29a, Certifier (Check

only one 29b. Signature and title of certific

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

01

20678

29c. License number D26358

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day RMISTEAD KICHARD 9:20 P M 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Berlin Atlantic General Hospital Worcester last birthday If Under 24 Hrs. Date of big (Month, Day, Age (In yrs. 72 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Months Days Hours Min **Director** 36 2834 Jan. Texas Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Yes 2 ☐ No Maryland Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13032 Wilson Ave. Unit 41 21842 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify White Specify: White 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Salesman Proctor-Gamble Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert Hammers Emma Baum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosemary H. Baum 13032 Wilson Ave. Unit 41 Ocean City, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Ceremation 3 Removal from State First 4 ☐ Donation 5 ☐ Other (Specify) State Crem. 16/13/12 Millsboro, DE 21. Signatule 22. Name and Address of Facility 108 William St. Burbage Funeral Home Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician/ CUTE MYOCARDIAL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 15 years b. ALTELIOSCUEROTIC CORDUNET VASCULAR Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy performe death? After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 2 No မ 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 24 hours after death. Funeral Director: A 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signat

State Registrar

DW 9+

PHYSICIAN

Cook

Roca

ATTENDING

700-B

Redistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print

RUDO

5

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

WESTMINSTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month/29/2012 Physician/ 7:40 PM Josephine M. Baran Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Golden Crest Assisted Living Hampstead, Carroll If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Dav. Year) Country Director 1 1 M 2 1 F 212-30-9087 79 10/24/1932 MD or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Director Examiner must be notified MD Carroll Westminster 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3630 Halter Rd. 21158 USA items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "natural", or i 1 ☐ Yes 2**X** No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: white 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) and Mental Hygiene. is marked other tha Project Mgr. Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Josephine Borowicz Howard Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 17020 Evna Rd., Parkton, MD 21120
Date 1, 20c. Location - City or Town, State (Son) Mark S. Baran, M.D. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place)

Mary S Cemetery 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/2/2012 Silver Run, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility PA 17340 Littlestown Little's F.H. 34 Maple Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): Exami or Attending Physician: The law requires that the death certificate be executed and-trar Due to (or as a consequence of): resulting in death) Last physician a s the burial-Physician/Medical Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the 8 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 IN 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be ATRIPULUE examiner? Other: 2 No 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of (Item 23a) (Type, Print) Business Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 20868 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 01 Medical 7017 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Min **Director** 216-48-0838 1 🗆 M 2 🗶 F 64 Maryland Dec 3, 1947 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** notified 28a-f Maryland Carroll 1 Yes 2 No Hampstead 10e Street and Number 10f. Zip Code 10a, Citizen of What Country? ms 23a or must be 1155 Caton Road 21074 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 þ 1 Never Married 2 Married 2 **X** No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 XNo Specify. "natural", Specify: white Completed 3 ¥Widowed 4 ☐ Divorced Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry within Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Elementary/Secondary (0-12) College (1-4 or 5+) Medical Records Supervisor 12 Maryland Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ည Thomas Insley June Garver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Kelley Summers, daughter 1155 Caton Road, Hampstead, MD 21074 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemete Granta pry or other place) 1 ☐ Burial 2 Cremation 3 ☐ Removal from State o Department of Important: If Important: If any injury or 6/11/2012 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory Winfield, MD Signature of Funeral Service License 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events burial-trar and resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) signed by the atter in the past 12 months? Pregnant at time of death Day Year 1 Yes 2 G 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗌 No Yes 2 1 Yes Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifica filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 2 4100 ၉ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28c. Injury at work? 27. Manner of Death Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number AT 243894 06/06/2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a hanc () mar 9

DHMH 17 Rev 06-2011

Registrar

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11, Day June 2012 Alice G. S. Barnes 12:38 A. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours 579-20-1635 **Director** 08/27/1923 Rairmount Hgts., Md ms 23a or 28a-f show must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Md. P.G. Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a event, the Medical Examiner must be Funeral 911 Hill Road 20785 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Yes Yes, Give 2 🔀 No within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black Specify: 3℃Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) P.G. County Elementary/Secondary (0-12) College (1-4 or 5+) Public Schools should be filed with hand Mental Hygien 7 is marked other th Teacher-Reading Specialist 5+ years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Chester Simms Gertrude Averett other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Constance Brown/Daughter 7406 Crane Place, Landover, Maryland 20785 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans Cem. 06/18/12 Cheltenham, Maryland Signature of Funeral Service Ligensee 22. Name and Address of Facility.
Henry S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N. F., Washington, D. C. 20019 Jany N. TRATI 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ ongestive lear + disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying sician and burial-transit Exami Cause (Disease or injury that initiated events resulting in death) Last rom Due to (or as a consequence of attending physician I for use as the buris Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 2 No of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending Division 1 Yes 2 No Accident Investigation 6 Could not be filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Example: to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completely Certifying Nurse Praditioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type 🔑 📢 3001 Hospital Drive, Cheverly MD. 20785 Alphonsus EziaquuoKoli 31. Date filed (Month, Day, Year) . Registrar's Pignature State Registrar

1 Yes 2 □ No

Year

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 06/16/2012 **Physician** Dale Nelson Bailey 6:45 a M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert 3110 Hickory Ridge Road Dunkirk Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 X M 2 □ F 77 577-46-6296 10/27/1934 DC Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 ☐ Yes 2 ▼No North Umberland Lottsburg Director the 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or ? or be 22511 U.S.A. 1315 Glebe Road "natural", or items 23a dical Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 □ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: er than "natur , the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Blanche Richards Charles Alexander Bailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any Injury or other trau Betty J. Bailey/Wife 1315 Glebe Road, Lottsburg, VA 22511 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Nurial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 06/19/2012 | Clinton, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of uneral Service Licensee Lisa M. Mounts 8200 Jennifer Lane, Owings, MD 20736 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Fibrosis 14/monary **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 □ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 9 Unknown 9 Unknown þ signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ş 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has by page 2 s autopsy certificate ! 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Nother Presidence 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 1 Inpatient After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

JRW 6

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rerabble, MD

2000 Medical Parkway, Suite 607, Annapolis, MD 21401 Beck, M.D. 31. Date filed (Month, Day, Year)

32. Registra s Signature JUN 19 2012

29c. License number

D46052

29d. Date signed (Month, Day, Year)

06/18/12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 12-04460 State of Maryland / Department of Health and Mental Hygiene Desimare Braxton 2012 20871 1- For State Certificate of Death Rea. No. Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death 3. Time of Death Physician/ Month June 13, 2012 1125 hrs **Medical Examiner** es Mario 4a/Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** University Hospital 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Days Hours Director Country) 1 M Usual Residence of Decedent 10d. Inside City Limits 10b. County 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e Street and Number air Funeral Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No Race - American Indian, Black White, etc. Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married Yes 1 Yes 2 No specify: If Yes, Give Year 4 Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical and Mental Hygiene. 18.Mother's Name (First, Midgle, Maiden Surr 17. Father's Name (First, Middle, Last Be 19a. Informant's 19b. Mailing Address rtment of Health a retant: If item 27 ver other traum: 20b. Place of Disposition (Name of cemetery, Itimore, 8urial 2 Cremation 3 Removal from State Donation 5 Other Specify: 21. Signature of Funeral Service Lice Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter **Physician** failure. List only one cause on each line 8etween Onset and /Medical Death a. Head Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Year Fetal death past 12 months? Pregnant at time of death 5 1 Yes 2 V No 9 Unknown Unknown detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed' death? Yes 2 No 1 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 2 FR/Outpatient 3 DDA Other: this ဥ 1 Yes 28a. Date of Injury (Month, Day,Year) FOUND: After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Assault FOUND Division 1 Natural 1 Yes 2 V No Pending within 24 hours after death.

To the Funeral Director: filled in by the Jun 13, 2012 1000 hrs 2 \_\_ Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be or Town, State) 814 N. Stricker St., Baltimore, MD determined (Specify) Residence 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c License number June 14, 2012 O.C.M.E. Hellown 30. Name and address of person who completed cause of death (Item 23a) Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001 OCME 2006

Registrar

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RUCKNER Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PG DISTRICT HEIGHTS 2408 WINTERGREEN AVE If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Days Hours Min Director 577-74-3042 1 M 2 X F MAY 20, 1953 DC Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other then "nature!", or items 23a or 28a-f shov ury or other treumetic event, it or Moston Examinat must be nothed at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PG DISTRICT HEIGHTS 1 Yes 2 □ No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? US 2408 WINTERGREEN AVE 20747 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 XNo Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) PRIVATE VICTIM ADVOCATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARGARET BUTLER JAMES WALTER BUCKNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOUSTON STREET, SUITLAND, MD 20747 ALYSTA GOFF/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 6-15-2012 CLINTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licensee 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 han ٤ eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Approximate Interval Between Immediate Cause (Final ER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): or Attending Physician: The lew requires that the death certificate be executed cate has been signed by the ettending physicien and page 2 should be detached for use es the burlal-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospitel or Attending Physiclen: The lew within 24 hours after death.

To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2. autopsy 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be ė Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending work? 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🚂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the Desire of Control Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 📢 of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0 99 se of death (Item 23a) (Typ me and address of person

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2012 JUNE 15, 2235 BERNICE V. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CENTER PRINCE GEORGE'S CLINTON Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth Hours (Month, Day, Year) 242-52-2467 80 **Director** 1 □ M 2 🗓 F MARCH 21, 1932 NC Usual Residence of Decede show 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f DC WASHINGTON 1 X Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? pe Funeral 3360 ERIE ST SE 20020 US Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? "natural", or i edical Examin 1 Never Married 2 X Married þ Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 No Specify: BLACK If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than " Elementary/Secondary (0-12) College (1-4 or 5+) 6 SCHOOL TEACHER D.C. GOVERNMENT other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o WILLIAM A. VAILES CALLIE HOBBS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health JOHNNY H. BUTLER, JR./HUSBAND 3360 ERIE STREET SE, WASHINGTON, DC 20020 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important; If it any injury or o 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State 6-25-12 SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN\_CEMETERY 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. Signature of Funeral Service Licensee M00981 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 23a. Part 1. Enter the disease, or complications that caus at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ule Artenoscierota Cardiovasci C disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) 1 Yes 2 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Tes 2 No 3 Probably 4 thomknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death e Hospital or Attending Ph 24 hours after death. e Funeral Director: After th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 06/15/2012 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Emma Jean Butler 8<sup>Day</sup> 2012<sup>Yea</sup> June 9:30 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hyattsville Prince George's Independence Court Of Hyattsville If Under 1 Year | If Under 24 Hrs Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 Hours 1-24-1933 Lincoln, NE 79 Director 505-36-0324 Usual Residence of Decedent of Health and Mental Hygiene. it is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director MD Prince George's Upper Marlboro 1 X Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with 20774 United States 11405 Snow Drop Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Race - American Indian. Armed Forces δ 1 Never Married 2 Married Yes Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: Black 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Seattle School System Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk ပ Myrtle George White 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11405 Snow Drop Ct. Upper Marlboro, Md Joseph Butler / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot cometery, crematory or other place)
Fort Lincoln Crematory 6/14/2012 1 Burial 2 X Cremation 3 Removal from State Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home Xely 1-14012 Road Brentwood, MD 20722 3401 Bladensburg 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death 20000 Physician/ Medical resulting in death) Due to (or as a c auence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a c burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown signed by the atter Month Day Year Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, to Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate work? 1 Natural injury 5 Pending 2 No 2 ☐ Accident 3 ☐ Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital
within 24 hours a
To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified Day, Year) 4860 30. Name and address of person who completed of death (Item 23a) (Type, Print) Suite 210 9470 Annapolis Rd. at 20706 Lanham, Md

State Registrar 31. Date filed (Month, Day, Year)

12-04528 Nicole Bennett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2012 20875

		1- For State Certificate of Death	Re	eg. No.	
Physicia	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Dear	th	3. Time of Death
Medical Exami	ner	NICOLE REISER BENNETT	June 15, 2		0900 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location or 7752 Willards By Pass Road Whaleyville	T Death	4c. County of Death Worcester	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under	r 24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir	thplace (State or
Director		506-98-6467 1 M 2 X F 35 Yrs. Months Days Hours	Min. SEP 15	5.1976 Foreig	nNEBRASKA untry)
		Usual Residence of Decedent	1	,	
y any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
land f shov	ō	DELAWARE SUSSEX COUNTY MILLSBORO			1 Yes 2 X No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Number 10f. Zip Code	11	0g. Citizen of What Cou	•
ith the		33580 WINDSWEPT DRIVE, UNIT 4201 19966	i=0 / 0===if · V====N=	UNITED ST.	
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", ur items 23a or 28a-f sho fraumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Married 13. Was Decedent of Hispanic Original Information of Hispanic Original Information (Information Information Inf		White, etc.	can Indian, Black,
fter de		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:		Specify: WHI:	re
ours a atura	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give k during most of working life. DO NOT usual control of the control		16b. Kind of Business/	ndustry
6 172 h an "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	use retired)	CHURCH DA	YCARE
5-0036 led within 7 Hygiene. other than	Ē	12 DIRECTOR  17. Father's Name (First, Middle, Last) 18. Mother's	s Name (First, Middle, N	CENTER	
115-	BeC		SARET ANN S		
2121 Muld be f Mental marke c event,	2	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number 19b)			, Zip Code)1 9966
MD d 2 sho lth and n 27 is		KEVIN EDWARD BENNETT (HUSBAND) 33580 WINDSWEPT D	R., UNIT 42	201 MILLSBO	RO, DE
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ur items 23a or 28a-f sho injury or ruther traumatic event, the Medical Examiner must be notified at once.	l	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite		T A Durial 2   Cremation 3   Nemoval nominitation	JUNE 22,201	2 O'NEILL	, NEB.
Salti emit. epartn oports jury e		21. Signature of Funeral Service Violensee 22. Name and Address of Facility			
	_	MO 1361 WATSON FUNERAL Days and the death. Do not enter the mode of dying, such as ca			BORO, DE  Approximate Interval
Physician /Medical		failure. List only one cause on each line.	irulac or respiratory arre	est, shock, of fleat	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Deau
		Sequentially list conditions, b			•
	iner	if any, leading to immediate Due to (or as a consequence of):			
4-4	Examiner	(Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):			
ecuted and transit	a E	<u>d.</u>			
ian ex	edical	UNPENDED AMENDED			
8760, ificate be ig physic	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic	pregnancy	23d. Date of delivery  Month	v Day Year
Box 68's death certiff the attending of for use as it	icia	past 12 months?			,
that the death certifined by the attending detached for use as t	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown	Loo Bill	1	
ires that the signed by I be detacl	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Par		bacco use contribute to 2 ✓ No 3 Prob	
ords, I			24a. Was a		topsy findings available
COFC	Completed		autop:	sy prior to death?	ompletion of cause of
ital Rec ician: The I s certificate I		25. Was case referred to medical 26.Place of Death (0	1 Yes 2	2 No 1 ✓ Ye	s 2 No
Division of Vital Records, P.O rat or Attending Physician: The law requires that tra after death.  **I Director: After this certificate has been signed by lef funeral director, page 2 should be detact	o Be	examiner?		Residence 6 🗸 Other	: Scene
n of \ding Phy	<b>-</b>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		now injury occurred	
ion tendin eath. tor: A	ation:	1 Natural 5 Pending FOWND: Jun 15, 2012 FOUND: 1 Yes 2 1 Yes 2	No Assault		
or Att or Att after de Direct	Certificati	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	. 28f. Location (S or Town, S	Street and Number or Ru	ral Route Number, City
DIVI spital or nours afte neral Dir	Se	4 Homicide determined (Specify) Woods off road	7752 Willards	By Pass Road , Wha	
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. The the Funeral Director: After this certificate has been signed by the attending i completely filled in by the funeral director, page 2 should be detached for use as the complete of the control of the	ical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occ			
To t with Th t	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mor	
		Conce Hallan O.C.M.E.		June 16, 2012	
	-	30. Name and address of person who completed cause of death (Item 23a)			
BA 6		Carol H. Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltin	more, MD 21223		
		31. Date filed (Month, Day, Year) 32. Registrar's Signature		- 5	

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bernice M Bowers 1:11 AM 2012 JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Manyland Medical Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Months 232-50-5674 **Director** 1 □ M **3** 🕱 F 01/29/1934 West Virginia Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 28a-f Maryland 1 Yes 2 X XNo Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r ō Funeral 7301 River Hill Road 20745 USA "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death bepartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Was Decedent Ever in U.S. 14 Race - American Indian. Armed Force Black, White, etc þ 1 Never Married 2 Married Yes 2 X XNo Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Completed XX Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Adm<u>inistrative Assistant</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Dennis Clayton Hill Gatha Jones 19a. Informant's Name/Relationship (Type, Print) 25414 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Bowers / Son 311 E. Washington St. Charles Town, West Virgina 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State Unk. Arlington Nat. Cem. 4 Donation 5 Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ck, or heart failure. List only one cause on each line. Immediate Cause (Final Physiciany respiratory disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** vascutitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 4 Pregnant a Other (specify) Year Pregnant at time of death been signed by the a should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4XX Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an his certificate has b autopsy performed Yes 2 X death?
1 Yes 2 No 24 hours after death. Funeral Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျှ 1 🗌 Yes 2 X No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 🗌 Yes 2 🗍 No 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) ٥ 1841589926 09 2012

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

JUN 14 2012

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tay SWA ZZ S. Green St, Baltimore, MD

32. Redistrar's Signature

Division or Vital Records, P.O. Box 68760 To the Hospital or A within 24 hours after c

ģ

Completed

Be ၉

Certification:

Medical

Dr Hariit 31. Date filed (Month, Day, Year)

2 2012

resulting in death)	Due to (or as a conseq							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 → No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 □Ectopic p			23	3d. Date of deli Month	ivery Day	Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to								
DEMENT				1 🗆	Yes 2□	No 3□Pr	obably	4 Unknown
CONCESTIVE HEART FAILURS  24a. Was an autopsy performed? In Yes 24DNo 1 Dyes								tings available
25. Was case referred to medical examiner?								
1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Spe						cify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d.				occurred	-	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specif	y, office	28f. Location (Street and Number or Rural Rou City or Town, State)			ıral Route	Number,	
	nysician: To the best of my known in the basis of examination and manner stated.							iuse(s)
29b. Signature and title of certifier	29b. Signature and title of certifier				29d. Date	9d. Date signed (Month, Day, Year)		
Halm			026907 Tu			F 27	2 0 1	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

<u>10:06 a</u>m

9. Birthplace (State or Foreign  $\widetilde{WV}$ 

10d. Inside City Limits

Approximate Interval Between Onset and Death

Cumberland, MD DISDA

1 DYes 2 □ No

State Registrar

DHMH 17 Rev 1/2001

completely filled in by the funeral

925 Bishop Walsh Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sidhu. ma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bennett, Jr. Allan James UNP Medical 4a. Facility Name (if not institution **Examiner** , give street and number, 4b. City, Town, or Location of Death 4c. County of Death 1 Year If Under 24 Hrs last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Min 218-38-6919 Director 1X M 2 □ F 71 Yrs 07/18/1940 Maryland Usual Residence of Decedent items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits Director MD Charles Cobb Island 1 🗆 Yes 2 🖁 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13000 Pine Grove Rd. 20625 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by Black, White, etc. "natural", or 1 Never Married 2 Married X Yes 1 Yes 2X No Specify: White 3 Widowed 4 Divorced Year or Dates 1961-62 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Norfolk/Southern (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Railroad Engineer Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Allan Bennett, Sr. should be Mary Rebecca Bowling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod 13000 pine Grove Rd., Cobb Island, M Martha C. Bennett/Spouse 20625 MĎ Page 1 and 2 altimore, 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Christ Church Cem. 06/25/12 20c. Location - City or Town, State Wayside, Maryland 4 Donation 5 Other (Specify) 21. Sig etu of Funeral Service 22. Name and Address of Facility Raymond Funeral Svc., M01517 La Plata, MD 20646 Washington Ave 635 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus ch line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical a consequence of: **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami ul or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and burial-trar that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending plant of for use as JE FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year ed by the a 9 Unknown 9 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificd completely filled in by the funeral director; I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending iniury 2 Accident
3 Suicide Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 6 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Certifying Nyrise Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nyrise Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date sig 30. Name and address of person (Item 23a) (Type, Print) State JUN 29

Registrar

			For	State of Mary				nd Mental Hy	giene	1.0	00070
			1 - State Registrar		Cer	tificate of L	Death		Reg. No. 2U	12	208/9
	Physicia		Decedent's Name (First, Middle, La     Anna	st) Elizabeth	1	Burger	r	2. Date of De		Year A	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give		1	4b. City, Town, or			4c. County of		0, 02 00
			Meritus Medical	Center		Hagers			1 '	ingto	n
	Funeral		Social Security Number     6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Bir Min. (Month, Da	th	9. Birthpla	ce (State or Foreign
	Director			□ M 2 <b>X</b> F	93 Yrs.	Widiting Bays	l llouis		7, 1918	Country	y sylvania
	nd thow	'n	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Loc	ation		oury 1	, 1310		d. Inside City Limits
	faryla Ba-f s tified	<b>Funeral Director</b>	MD Washingt	on H	agerstown	1					1 X Yes 2 □ No
	the N	Ē	10e. Street and Number			10f. Zip Code		T	10g. Citizen of W	hat Country	y?
	s 23a	era	433 Vermont Ave.			21740			U.S.	Α.	
	death item ner n	Fur	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. W	as Decedent of Hi	spanic Origin' n. Mexican. P	? (Specify Yes or No- uerto Rican, etc.)	14. Race	- American	
36	after Il", or xamii	d by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		☐ Yes 2 🗶 No		acree ( noun, crop)		, White, etc	I
9	atura cal E	Completed	15. Decedent's E	Year or Dates.	16a Deced	ent's Usual Occup	ation			White	
215	72 h an "n Medi	mpl	(Specify only highest gr Elementary/Secondary (0-12)		(Give k	ind of work done of NOT use retired)		working	16b. Kind of Bus	iness/Indu	stry
21215-0036	withii giene er th		10	College (1-4 of 5+)	Homen	naker			Domesti	lc	
nd	filed tal Hy d oth event	To Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,	Maiden Surname)		
Зlа	Men Men narke	F	George Hays				Gail	Yates			
Mai	I and 2 should be file Health and Mental F tem 27 is marked o other traumatic eve		19a. Informant's Name/Relationship (7	,				r Rural Route Numbe			de)
ė,	and Healt Healt tem 2		She1by J. Resh/Da 20a. Method of Disposition		Ob. Place of Dispos		Road, I	Hagerstown Date		740	
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 🔀 Burial 2 🗆 Cremation 3 🗆	Removal from State		atory or other plac	e) 6/	22/2012	20c. Location - C	-	
altir	artme sortar injur		4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Licep	77				Rest Have			
m	permi Depar Impor any ir	Ŋ	1 S. Mark S.	ملائد				a Ave., Ha			
п			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	plications that caused the						А	pproximate
	Physician/		Immediate Cause (Final disease or condition	- magnitude	A CEPA	3Km 1	3115	₹D			nterval Between Inset and Death
	Medical Examiner		resulting in death)	Due to (or as a cor	nsequence of:						
	Lxammer	'n	Sequentially list conditions,			かってり	thy	PERTE	Mr 15M		
	sit sd	nin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cor	nsequence of):						
	ecute and	Examiner	that initiated events resulting in death) Last	c. Due to (or as a cor	nsequence of):					+	
0	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d							
3760	ficate b g physi as the t	<b>Jedi</b>		d		:					
c 687	eath certifica attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr		Ectonic prognana	.,		23d. Date	of delivery	
Box	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 Pregnant at time		Other (specify)	у		Mont	h Da	ay Year
P.0.	at the	Phy	9 Unknown  Part II. Other significant conditions c		at regulting in the un	idarking aguas siy	en in Doubl				
	requires that the des been signed by the s should be detached	l by	Tartii. Other significant conditions	ontributing to death but no	A resulting in the un	denying cause giv	eli ili Fart I.		bacco use contrib		bly 4 Unknown
ğ	requir	etec									
Records,	The law ate has page 2 s	Completed				<u>.                                    </u>		24a. Was a autop	sy pri	ere autopsy or to comp ath?	findings available eletion of cause of
<u> </u>	ician: The certificate rector, pag		25. Was case referred to medical				oo of Dooth //	1  Yes		Yes 2	□ No
Vita	Attending Physician: ar death. ector: After this certific by the funeral director,	To Be	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	2 ☐ ER/Outpatient	Othe	r:	ng Home 5 - Resid	anno 6 🗆 Othor	(Chaoifu)	
o	ig Ph ter thi neral		27. Manner of Death	28a. Date of injury (Month, Day, Yea	28b. Time of	28c. Injury	at		ow injury occurred	(Specify)	
o	endin eath. or: Aff	fica	1 Natural 5 Pending 2 Accident Investigation	1	injury	M 1 □	Yes 2 No	)			
Division of Vital	or Att	Certificate:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - a building, etc. (Sp	At home, farm, stree	et, factory, office		28f. Location (S City or Tow	treet and Number n, State)	or Rural Ro	oute Number,
Ξ	pital ours a eral D filled			The second second							
	24 hc 24 hc Fun letely	Medical	(Check 2 Medical Exami	sician: To the best of my k	nation and/or investig	gation, in my opinio	n, death occur	red at the time, date a	nd place, and due to	the cause	(s) and manner stated.
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifica completely filled in by the funeral director,	Σ	only one) 3 ☐ Certifying Nurs 29b. Signature and title of certifier	se Practitioner: To the bes	t of my knowledge, c	29c. License			ne cause(s) and mar 29d. Date signed (i		
	Man		> 5-10	mer	am	Do	B(3	9111	OF	141	7012
	10 /2.		30. Name and address of person who	completed cause of death	(Item 23a) (Type, Pri	int)	TU	70	~ 0 (		0-11
	1		EMERIC	VALMEY	2, Mt	9747 W	Me	D. TR	, thre	ers	CIM MINES
	Stat		31. Date filed (Month, Day, Year)  JUN 29 2012	32. Registrar's S	ignature sall						
*	Registra	1	JUN AU LUIL A	many h.	7						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 06 Richard Clark Childress 2012 0500 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lookabout Manor Nursing Home Westminster Carroll If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours 02/05/1934 **Director** 244-42-3425 1**X** M 2 □ F 78 Usual Residence of Deced or 28a-f show e notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Westminster 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be Completed by Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 603 Oneta Drive 21157 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1X Yes 2 No 1952If Yes, Give If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", Specify: White 3 Widowed 4 Divorced Year or Dates 1956 f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) electrical engineer Domino Sugar Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Paul W. Childress Margaret Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Childress/wife 603 Oneta Drive, Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot ☐ Burial 2 XCremation 3 ☐ Removal from State cemetery, crematory or other place, 06/09/2012 4 ☐ Donation 5 ☐ Other (Specify) Carroll Hampstead, MD Cremation Signature of Funeral Service Use 22. Name and Address Produtts Funeral Home and Chapel, PA 412 Washington Road, Westminster, MD 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Al & heimar Physician/ disease or condition resulting in death) 4245 Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of: cause. Enter Underlying Cause (Disease or injury Examin burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Id be detached for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate bethin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Day Month Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been significate has been significated and significated and all the second of the secon 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Do Machtern 2 **V** No Hospital Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury **✓** Natural 5 Pending Accident Investigation □ Accider
 □ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical within 24 hours to the Funer completely file 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 29c. License number 590 29d. Date signed (Month, Day, Year) 06-08-2012 ause of death (Item 23a) (Type, Print) 30. Name and addre of person who completed 21157 125 Airport Dr., Westminster, MD Philip Ruzbarsky .D. rar's Signature State Cknewa Registrar

Joseph Patrick Cannon, Jr.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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	$\cup$	i form		$\cup$	$\cup$	U	

		1- For State Registrar		Certific	cate of Dea	ath			Reg. No.	20	12 2000
Physici ^edical Exam		1. Decedent's Name (First, Middle, La Joseph Patr:	ick Cannon,	Jr.				2. Date of De Month June 23,	Day 2012	Year	3. Time of Death 0903 hrs
		4a. Facility Name (if not institution, g 11476 Rawhide Road			Lus	by	Location of D		Ca	County of Deat alvert	h
Funeral Director		226-96-8294	Sex         7. Age (In           XM         2           F         5	yrs. last bi	rthday) If Ur Mor Yrs.	nder 1 Yea		Min	9/195	Foreig	rthplace (State or gn puntry) PA
Maryland 28a-f show any 1.at once.	JO.	Usual Residence of Decedent  10a, State 10b, County  MD Calv		•	n or Location						10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	I Director	10e. Street and Number 11476 Rawhide	Road		10f. Z	Zip Code 2065	57		10g. Citize	en of What Cou USA	ntry?
s after death with ral", or items 2 liner must be n	by Funeral		d If Yes, Give Year	No	If Yes, spe	cify Cubar	specify:	( Specify Yes or Nerto Rican, etc.)	Sp	White, etc. pecify:	ican Indian, Black, White
5-0036 led within 72 hours Hygiene. other than "natu	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	ed) 16a.	Decedent's Usua during most of w Se	vorking life	Donotuse Manag	retired) er			e Company
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica	Be	17. Father's Name (First, Middle, Las Joseph Pat	rick Cannon	, Sr.			Rita		J		Moore
ore, MD 2121: s. I and 2 should be fi. of Health and Mental I. If item 27 is marked her traumatic event,	ဥ	19a. Informant's Name/Relationship ( Margaret Cannor	/ Wife	1	1476 Ra	whide	Road	or Rural Route Nu Lusby,	MD 2	0657	
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		4 Donation 5 Other Specification of Funeral Service Lice	Removal from State	crema	of Disposition (Natory or other place Cremato: 22. Name ar	e) ry	0	Date 6/26/201		inton,	•
Physician	1 8	23a. Fart I. Enter the disease, or com	plications that caused the d	leath. Do n				e Calver			Approximate Interval
/Medical Examiner		failure. List only one cause on a Immediate Cause (Final disease or condition resulting in death)	. Atherosclero  Due to (or as a consequent		Cardiova	scul:	ar Dise	ase			Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequer	nce of):							-
cuted ind transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):							
760, ficate be executed g physician and the burial - transi	Medical		AMENDED 23a, 27 #12per 23c. If yes, outcome of	7,per FH.G	<b>me,g929</b> 930,8/22	<b>7-1</b> /2012	7-12 sm	1	Look		
	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	1 Live birth 4 Pregnant at time	-6 -l4b	2 Fetal death 5 Other (Sp		Ectopic pre	gnancy		Date of delivery Ionth E	Y Day Year
ords, P.O. E w requires that the d is been signed by the should be detached	ā	Part II. Other significant conditions	contributing to death but	not resultir	ng in the underlyin	ng cause g	iven in Part I.				the cause of death?
Rec The la icate ha	Completed							1 Yes	psy orm <u>ed</u> ?		topsy findings available completion of cause of
Vital   ysician: ysician: his certifi director,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	FR/O	Outpatient 3		of Death (Che	ck only one) sing Home 5	Residence	e 6 🗸 Other	- Scene
C = 2 2	ıtlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day,Year)		Time of Injury	28c. Injur	y at Work?	28d. Describe			. 00076
Division of To the Hospital or Attending Physical Action of September 1 To the Fuorral Director: After the Completely filled in by the funeral	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	be 28e. Place of Injury -	At home, f	arm, street, factor	ry, office be	uilding, etc.	28f. Location or Town,		Number or Ru	ral Route Number, City
To the Hospital within 24 hours. To the Fuoeral completely filled	edical C		ian: To the best of my known: On the basis of examination and manner stated.								
	Me	29b. Signature and title of certifier	MM	4	7	9c. License O.C.M				te signed (Mor	nth, Day, Year)
		<ol> <li>Name and address of person who Zabiullah Ali, M.D. Ass</li> </ol>	completed cause of death ( stant Medical Exami	,	) 00 W. Baltimo	ore Stree	et, Baltimor	e, MD 21223			
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Sig		back	j					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Arthur Stanley Conward 10, 2012 June 0044 hrs. Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** 9. Birthplace (State or Foreign Days 019-20-8527 82 **Director** 1 **X**M 2 □ F March 4,1930 Massachusetts Usual Residence of Decedent 28a-f show 10b. County Director 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number ö event, the Medical Examiner must be 10g. Citizen of What Country? Funeral 23a 11235 Oak Leaf Drive; Apt. B311 20901 United States 12 Was Decedent Ever in 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? US Navy 1 M Yes 2 No 15 Yes, Give Aug. 1950 Year or Dates. Aug. 1954 14. Race - American Indian. Black, White, etc. ō by 1 Never Married 2 X Married hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural". 3 Widowed 4 Divorced Specify: Black Completed 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Federal Aviation nentary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other tl 12th grade Air Traffic Control Specialist Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Oswald Conward Timber permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. injury or other traumatic Florence Nettie 19a. Informant's Name/Relationship (Type, Print)
Mary Arnida Jones Conward (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Amelia Johnson (Daughter) 3601 Kidder Road; Clinton, Maryland 20735 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 20, 2012 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, 4 ☐ Donation 5 ☐ Other (Specify) Maryland Cheltenham Veterans Cemetery Maryland 22 January of Facility R. N. Horton Company Morticians, M01/421 Inc.:600 Kennedy Street, N.W.: Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. id. Cardiac arry disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner coronary Sequentially list conditions Examin cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Spiration nding physician and use as the burial-trar Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav Pregnant at time of death
Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 0 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 PNo Other: 1 🗌 Yes ည Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Yes Accident Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 the 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of 62435

State Registrar

00

200 ward

10110

molecularisc.

Rockvill

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

yad

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#11&#18perfuneralhome6/22/2012/cchd/ba Certificate of Death Reg. No. For State Registrar 20883 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2012 Physician/ Month Mary Ann Claggett 9:15 June  $\mathbf{p}$ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chesapeake Shores Lexington Park St. Mary Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Funeral Month, Day, Year) Days Hours 1 🗆 M 2 🕮 Months Min. Maryland 51 Director Nov <u>214-72-4543</u> Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10a. State 10d. Inside City Limits Director 1 🛣 Yes 2 🗆 No Maryland Charles Indian Head 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Jonquil Place 20640 U.S.A. "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes Yes, Give 2 🗆 💢 o Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Completed 3 X Widowed 4 X Divorced Year or Dates d 2 should be filed within 72 hours alth and Mental Hygiene.
127 is marked other than "natura er traumatic event, the Medical E White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Her Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Allen Smith Mary R. Quinlin Quinlan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is Mother 19 Jonquil Place, Indian Head, Md. 20640 Mary R. Smith other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 17, 2012 2 1 ☐ Burial 2 ☐X remation 3 ☐ Removal from State Alexandria, Virginia 4 Donation 5 Other (Specify) injury Metropolitan Funeral Service 21. Signatur of Funeral S Wininams Function Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, 20640 se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dise shock, or heart fail re Approximate Interval Betwe e. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Deat Physician/ Medical resulting in death) a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine sician and burial-transit Cause (Disease or iinjury that initiated events certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown 1 | Yes 2 No 9 | Unknown signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 2 0 N 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: To the Hospital or Attending Natural injury work? 5 Pending 2 No ☐ Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and ti d (Month, Day, 29d. Date sign

P.O. Box 68760

Records,

Division of Vital

State Registrar M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21412 Great Mills Rd., Lexington Park,

Md.20653

Amir Alikhani

Registrar's Signatur

			State of Marylan	•			lental Hy	giene	2 20001
			Registrar	Cer	tificate of De	eath		Reg. No. ZUI	2 20004
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day Year	3. Time of Death
	Medic	al	James Edward Dolan  4a. Facility Name (if not institution, give street and number)		T 41 - 02 - T 1 -		June 8	I .	9:02 p <sup>M</sup>
	Examin	er			4b. City, Town, or Lo	ocation of Death		4c. County of De.	ath
9	Funeral		Laurel Regional Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. In	ast birthday)	Laurel  If Under 1 Year   It	f Under 24 Hrs.	8. Date of Birt	P.G.	irthplace (State or Foreign
	Director			38 <sub>Yrs.</sub>	Months Days I	Hours Min.	(Month, Day Jan. 4,	v, Year) C	shington, DC
	M		Usual Residence of Decedent					1721 "	
	yland -f shc ed at	cto		y, Town or Loc					10d. Inside City Limits
	r 28a notifi	Director	MD P.G.  10e. Street and Number	2117	rer Spring				
	ith th	rall						10g. Citizen of What C	ountry?
	ath w	Funeral	3152 Gracefield Road, #622  11. Marital Status 12. Was Decedent Ever in U.S.	3. I13. V	20904 Vas Decedent of Hispa	anic Origin? (Spe	cifv Yes or No-	USA 14. Race - Am	erican Indian
9	er de or ite mine	by F	1 Never Married 2 Married Armed Forces? 1 Mysel Pes 2 No If Yes, Give Yletna	11	f Yes, specify Cuban, I	Mexican, Puerto I	Rican, etc.)	Black, Wh	te, etc.
21215-0036	ırs aft ıral", I Exal		3 ☐ Widowed 4 ☐ Divorced If Yes, Give V1etna Year or DatesKorea	am & 1	Yes 212 No 8	Specify:		Specify: Wh	ite
2-0	2 hou "nati	plet	15. Decedent's Education (Specify only highest grade completed)	16a. Decec	dent's Usual Occupation	on ing most of working	ng	16b. Kind of Busines	s/Industry
121	thin 7	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	life. D	ONOTuseretired) Stical Eng			Navy	
20	Hygie Hygie other ent, th	യി	17. Father's Name (First, Middle, Last)	Hogi			(Eirst Middle	Maiden Surname)	
au	be filk ental ked c	To	Lawrence Edward Dolan				,	Donnell	
ary.	nould nd Me mar		19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	a Address (Street and			r, City or Town, State, 2	(ip Code)
Š	d 2 sk alth a 27 is		Mary M. Dolan/Wife	4.				Silver Spr	
re,	1 and of Hei Fitem		20a. Method of Disposition 20b. F	Place of Dispo	sition (Name of	0	Date	20c. Location - City of	
E	Page nent c ant: II		tx☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ington	natory or other place) National emetery	Ju	$[812^{9},]$	Arlington	, VA
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	3	21. Signature of Funeral Service Censee	F	rancis Address C				ng, MD 20901
r		- 0	23a. Parv 1. Enter the disease, or complications that caused the deat						Approximate
, detail	Ph_sician/		shock, or heart fail/Gre. List only one cause on each line.  Immediate Cause (Final disease or condition Acute Myoca	rdio1	Inforation				Interval Between Onset and Death
	Medical		disease or condition resulting in death)  ACULE MYOCA  Due to (or as a consequence of the content of the conten		Intarction	1			1 hr
	Examiner		Sequentially list conditions, b. Coronary Ar		isease				unknown
	n ti	Examiner	cause. Enter Underlying						
	and -trans	xan	Cause (Disease or injury that initiated events resulting in death) Last  C. Hypertensio  Due to (or as a consequence of the consequence)						
	ate be executed hysician and the burial-transit	dical E	Hypercholes	,	mia				
760	cate physis the	ledi	d						
Box 687	eath certificat attending ph d for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregna		Totonio			23d. Date of d	elivery
30X	death e atte	sicia	in the past 12 months?  1		Ectopic pregnancy Other (specify)			Month	Day Year
o.	requires that the des been signed by the s should be detached	Phy	9 🗔 Onknown						
P.O.	s that gned be de		Part II. Other significant conditions contributing to death but not res Pacemaker, Congestive Heart Fa	_				bacco use contribute	
rds	een s	eted	Prostate Cancer						Probably 4 🔀 Unknown
000	law r has b le 2 sl	Completed by	riostate cancer				24a. Was autop		utopsy findings available completion of cause of
æ	: The cate r, pag						1 🗌 Yes		es 2 🗆 No
ita	ician certifi recto	m	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1   Inaction 2		Other	of Death (Check			
<u>&gt;</u>	Phys r this eral di	2	1 Yes 2 No 1 Inpatient 2 2 2 27. Manner of Death 28a. Date of injury	ER/Outpatien 28b. Time of	t 3 L DOA 28c. Injury at			lence 6 Other (Spe ow injury occurred	cify)
o Li	nding th. : After e fune	cate	1 Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident Investigation	injury	work?	s 2 🗆 No	ed. Describe n	ow injury decoursed	
isic	Atter er des ector by th	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At ho		eet, factory, office	1		treet and Number or R	ural Route Number,
Division of Vital Records,	tal or rs afte al Dir		building, etc. (Specify	7			City or Tow	n, State)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowl 2 Medical Examiner: On the basis of examination only one) 3 Certifying Nurse Practitioner: To the best of my knowl 2 Medical Examiner: On the basis of examination only one)	ledge, death on and/or invest	occurred at the time, digation, in my opinion, death occurred at the	late and place, and death occurred at time, date and place	d due to the ca the time, date a	use(s) and manner as and place, and due to the	stated.  cause(s) and manner stated. as stated.
	To th withir To th	2	29b. Signature and title of certifier	, y y	29c. License nu	umber		29d. Date signed (Mon	
	1 - 1		117 01//		\ \	1660		618	1 -
	5		Wary by		P	1000	•	610	712
K	54		30. Name and address of person who completed cause of death (Item Wang Kwong Koon, MD 7300 Van					010	712
h	Stat	te		Dusen	irînt)			0/0	//2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ Anthony DeLouis Peter 2012 Tune Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** National Institutes of Health Bethesda Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) Months Days Hours (Month, Day, APRIL 1 178-40-0013 1 X M 2 □ F 63 Min. **Director** 8 Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director PA ALLEGHENY McKEES ROCKS 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28 ST. JOHN STREET 15136 US Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: WHITE 3 ★ Widowed 4 □ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PSYCHOLOGIST PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MARCO DeLOUIS VIRGINIA FEDELE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 ST. JOHN STREET, McKEES ROCKS, PA 15136 JOE DeLOUIS/BROTHER 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 6-18-2012 McKEES ROCKS, PA ST. MARY'S CEMETERY 4 Donation 5 Other (Specif Signature of Funeral Service Lic 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease or cor shock, or heart failure. List only Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MIONIC 1400 disease or condition Medical resulting in death) Due to (or as a consequence of Examiner weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? for Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No. page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 1 Tyes 2 N Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 2 Accident 5 Pending death. 1 Yes 2 No after death Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Dav. Year) D69053 2

Registrar

10 Center Drive, Bethesda, MD 20892

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

PARKER

Anry

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2/012 Month May Genevieve May Eckard 22, 1713 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospice Dove House Westminster Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Jan 31, 1930 Months Days Hours 1 M 2 X Mary land 82 Director 215-26-1784 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Maryland Taneytown 1 🗌 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3830 R Old Taneytown Road 21787 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Seamstress 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Russell Thomas Della Wentz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Eckard, son 3830 Old Taneytown Road, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Grace UCC Cemetery 5/26/2012 4 ☐ Donation 5 ☐ Other (Specify) Taneytown, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician n Medical resulting in death) Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed s been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months Month Year Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed cate has been ; page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Tyes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No Hospice မ 4 Nursing Home 5 Residence 6 Other (Spe 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After s after dea. 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature

State

Registrar

Name and

31. Date filed (Month, Day, Year,

West minuter MD

dress of person who completed cause of death (Item 23a) (Type,

anewa

32. Redistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Bess Everett Addie Gertrude 12:15A 06 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Springvale Terrace Assisted Living Silver Spring Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs g. Birthplace (State or Foreign 6. Sex If Under 8. Date of Birth **Funeral** Months Days Hours Min. 579-14-3809 Director 1 □ M 2 🔀 F 105 10/04/1906 NCUsual Residence of Decedent 28a-f shov 10a. State notified at 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 No Silver Spring MD Montgomery 10f. Zip Code 10e. Street and Numbe ò 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral USA 20910 8505 Springdale Rd 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕱 No Specify: Specify: Black 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Luvenia's should be filed with and Mental Hygien rs marked other th 12 Beautician event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 traumatic Johnnie Vest Estella Bess 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 7004 Woodscape Dr. Clarksville, MD 21029 Andrew Bonds, Jr./Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Nurial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 06/11/2012 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Signature of Funeral Service Licenses Washington, DC 20011 4217 9th St. NW art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Minutes Beath Immediate Cause (Final Physician/ Acute Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No his certificate has buildirector, page 2 sl 24a. Was an autopsy performe 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Assisted Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6X Other (SpecifyLiving 1 🗆 Yes 2 🔀 No Hospital: ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 K Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of tifler 29c. License number 29d, Date signed (Month, Day, Year) June 8, 2012 D09834 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry N. Rosenbaum, MD 3720 Farragut Avenue 20895 Kensington, Maryland 31. Date filed (Month, Day, Year 32. Registrar's Signature State 9 2012 Registrar

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2012 10:12 p.m/. 3. Shawn Michelle-Flannigan Cavanagh June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice House of St. Mary's St. Mary's Callaway cial Security Number If Under 1 Year . Age (In vrs. last birthday If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours (Month, Day, Year) **Director** 559-73-8185 1 🗆 M 2 🗓 F Usual Residence of Decedent 45 11/19/1966 Canada 28a-f show 10a. State 10b. County notified at 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 20960 Robert Eliff Place 20653 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education and Mental Hygie is marked other Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Paul Flannigan injury or other traumatic Joan Marie Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Thomas P. Cavanagh/Husband 20960 Robert Eliff Place, Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 06/05/2012 Charlotte Hall, MD Signature of Funeral Sergio Icens
Michele Brassilette 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 MU1652 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate terval Between Onset and Death ETASTATIC Immediate Cause (Final Physician) disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the phy ass attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown the. 9 Unknown P.O. ed by the signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 Yes 2 No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice House Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 4 hours after death.

-uneral Director: After thely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident 5 Pending iniury 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4  $\square$  Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title ertifi 29d. Date signed (Month, Day, Year) 68846 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5) eme 25500 Point Lookout Road, Leonardtown, MD Amir Khan M.D. 20650 egistrar's Signatu 5 201 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Johnny Boy Forrester 201<sup>Ye</sup> 8. 1944 hrs. June. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year] 965 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Director 578-98-2088 1 X M 2 🗆 F 46 November 4. Washington.D.C. 10b. County 10c. City, Town or Location Director r 28a-f s notified Washington District of Columbia 1X Yes 2 No ō 10e. Street and Number items 23a or ner must be n 10g. Citizen of What Country? Funeral 2800 Jasper Road, S.E.; Apt. 202 20020 United States "natural", or iteπ ledical Examiner r 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Security Guard Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental ဂ္ be f Joseph Wilson Ruby Forrester Lee Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20747 <u>s</u> Health em 27 Page 1 and 2 Shirley Ann Rollins (Sister) 6535 Hil-Mar Drive; Apt. 202; Forestville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State June 22,2012 4 Donation 5 Other (Specify) Herixage Memorial Cemetery Waldorf, Maryland 21. Signature of Juneral Service 22. Name and Address of Facility R.N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D..C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIAC ARRYTHMIA FATAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atte d be detached for in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\boldsymbol{X}$  Unknown this certificate has been signal director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 X No 2 No 1 Yes Division of Vital completely filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 Yes 2 X No Hospital Other: ဂ 1 Inpatient 2 K ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director: After th 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and D0070864-MD completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

State Registrar Date filed (Month, Day, Year

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	Pleas	se Type or Print in I						.egible.	
	For State Registrar	State of Marylan		rtment of l tificate of L		/lental Hy	giene Reg. No.	2012	2 20890
Physician/ Medical	1. Decedent's Name (First, Middle,	Last)	P			2. Date of De Month	eath Day	la Year la	3. Time of Death
Examiner	4a. Facility Name (if not institution,	give street and number)	hab	4b. City, Town, o	r Location of Death	n Me	4c. Co	ounty of Death	e George
Funeral Director	578 52 7772	5. Sex 7. Age (in yrs. le	as <i>t birthd</i> a <i>y)</i> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da April 2	ay, Year)	Cour	place (State or Foreign ntry) ington, DC
aryland a-f show fied at	Usual Residence of Decedent  10a. State 10b. County		y, Town or Loc						10d. Inside City Limits 1 ☐ Yes ŽXX No
leath with the Maryland tems 23a or 28a-f sho er must be notified at Funeral Director	Maryland Prince (		TOIL W	ashington 10f. Zip Code			_	n of What Cou	intry?
eath wit	12021 Livingstor	12. Was Decedent Ever in U.S			lispanic Origin? (Spe			ted State Race - Americ	
irs after d ural", or it I Examine ed by F	1 ☐ Never Married 2 ☐ Marrie 3 🙀 Widowed 4 ☐ Divorced	Armed Forces?  1  Yes XX No If Yes, Give XX Year or Dates.		Yes, specify Cuba	an, Mexican, Puerto Specify:	Rican, etc.)	Spe	Black, White,	etc. ack
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  Important: If time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	15. Decedent (Specify only highes Elementary/Seconday (0-12)	's Education t grade completed)  College (1-4 or 5+)	(Give k life. DC	NOT use retired)	during most of work	ing		of Business In	ndustry
oe filed with intal Hygier ked other I c event, th	12 17. Father's Name (First, Middle, La		<u>  Secur</u>	ity Guard	18. Mother's Nam	e (First, Middle, ertha Bul	Maiden Sun	rvices name)	
should b and Mer is mark aumatic	Charles T. V		19b. Mailin	g Address (Street	and Number or Rura			wn, State, Zip	Code)
and 2 Health tem 27 other tr	Ricky Love (son) 20a. Method of Disposition	20b. F		Skipjack Sition (Name of	Drive, Fort	Washing		20744 tion - City or T	own. State
Page 1	1 X Burial 2 Cremation 3 4 Donation 5 Other (Sp	3 ☐ Removal from State C	emetery, crem	atory or other plac	cenetery Jur				
permit. Departr Imports any inji	21. Signature of Funeral Service Lic		22.	Name and Addre	ss of Facility Lee	Funeral:	Home,In	c 6633 0	ld Alexandria
hunician/	23a. Part J. Enter the disease, or c shock, or heart failure. List on Immediate Cause (Final	complications that caused the death		,			rrest,		Approximate Interval Between Onset and Death
hysician/ Medical Examiner	disease or condition resulting in death)	Due to (or as a consequ		MULLING.	- Pul		C 00 00	2	
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5 5 T IM	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):						
og physician as the burial		d	HY P	er tens	100				
ath cert attendii for use cian/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of c	al death 3 🗌	Ectopic pregnand Other (specify)	су		230	d. Date of deliv	very Day Year
requires that the ue should be detached should be detached letted by Physical	Part II. Other significant condition	•	-		ven in Part I.			contribute to t	the cause of death?
cate has been signed page 2 should be d	Periphe	Discove rai Vascular rcholestrol	Disc	ase		24a. Was	an 2	24b. Were auto	ppsy findings available
noning Priysician: The taw ath.	Hype	rcholestrol				auto perfe 1 🗆 Yes	psy ormed? No	prior to co death? 1 \(\sum \) Yes	ompletion of cause of
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re this contact the contact th	27. Manner of Death	1 ☐ Inpatient 2 ☐ 28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur	y at Nursing Ho	ome 5 L Resi 28d. Describe			y)
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une nospira hin 24 hours the Funeral appleted filled	(Check 2 Medical Ex	Physician: To the best of my knowl aminer: On the basis of examination Nurse Practioner: To the best of my	n and/or investi	gation, in my opinie	on, death occurred a	t the time, date	and place, an	d due to the ca	ause(s) and manner stated.
with Con	29b. Signature and title of certifier	1 Ban Dr	UP TENIE	29c. Licens	R 1011	1-7	29d. Date s	igned (Month,	Day, Year)
mas	30. Name and address of person w	ho completed cause of death (Item	1 61	int)	Nd			00	. 2 200
State Registrar	31. Date filed (Month Day Year)	2012 32/Registrar's Signat		west .	1-01.				

State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 2012 Genevieve Lenore June 1935 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral Days 1 🗆 M 2 🗶 F Hours 08/07/1922 Director Wisconsin 394-14-1149 89 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director St. Mary's Hollywood 1 Yes 2 No Maryland 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral United States 20636 23838 Louise Lane 12. Was Decedent Ever in U.S.
Armed Forces?
1 ▼ Yes 2 □ No
If Yes, Give
Year or Dates. 1943-45 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u></u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones. Library of Congress Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပု Mildred Warner Α. Wipfli Car1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23838 Louise Lane, Hollywood, Maryland 20636 Geraldine Pharis / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Charlotte Hall, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 06/04/2012 Signature of Funeral Service Licensee

Mithuen a Santivasci M00872 22. Name and Address of Facility Leonardtown, Maryland 20650 Brinsfield Funeral Home, 22955 Hollywood Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Congestiv disease or condition resulting in death) Medical Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last burial-transi and Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? detached for Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sibuillation 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 N After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Hospital Medical 29a. Certifier 1-Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year, D60888 03 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Coterne

Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month

5

Dr. Rakhi Krishnan, St. Mary's Hospital, 2500 Pt. Lookout

egistrar's Signature

Maryland 20650

Road, Leonardtown

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 2012 13, 4:20 P.M Wilda Griffin - Wildman June Loraine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6780 Hallowing Point Road Prince Frederick Calvert 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 01/23/1935 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🗓 F 217-30-0985 77 Virginia Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Expriser critical to realth a proces. Director 1 ☐Yes 27 No Calvert Prince Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 6780 Hallowing Point Road 20678 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ∐Yes 2**X**]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ironworkers Elementary/Secondary (0-12) College (1-4or 5+) International Union executive secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franklin Tusing Virginia Lelia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne A. Wildman, husband P.O. Box 191, Benedict, MD 20612 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 106/18/2012 |Brentwood, MD 22. Name and Address of Facility 21. Signature of Funeral Service Liger Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Ent., the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cluse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** lung /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐Yes 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 ☐ Pending investigation nours after death.

neral Director: Al 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of who completed cause of death (Item 23a) (Type, Print) JRW Prince Frederick M Molde M 238 SOU MON 31. Date filed (Month, Day, Year) 32. Registra State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Francis S. Goulden MAY 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL MEDICAL PENINSULA NICOMICO 544130414 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days Director 190-12-2116 1 **X**M 2 □ F 88 1924 Feb 27, Pennsylvania or 28e-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Salisbury 1 ☐ Yes 2 No Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with iment of Health and Mental Hygiene. ent. If item 27 is merked other than "naturel", or Items 23e 21804 1110 Health Way Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Agned Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 ☐ Divorced WWII Specify: White th and Mental Hygiene. 27 is merked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Catholic Church 8 Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Francis Goulden Frances Sprankle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Goulden, son 2317 Abbott Drive, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Importent: If ite any Injury or ot once, 1 X Burial 2 Cremation 3 Removal from State New St Joseph's Cem 5/30/2012 Emmitsburg, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W Main St, Emmitsburg, MD 21727 Pant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 510515 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner obstructiva Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physicien and I for use as the burlal-transit or Attending Physician: The lew requires that the death certificate be executed YACUMONIA resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown After this certificate hes been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 
Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ determined

Box 68760 P.0 Division of Vital Records, after death \_ within 24 hours aft

To the Funerel Dir

completely filled In

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State

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E

CARROLL St. SALISBALLY MO

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D68222

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Giudice Physician/ John 20 /2 5:24 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HIMOR If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Security Numbe 9. Birthplace (State or Foreign **Funeral** Months Hours 220-38-6808 Director 1 X M 2 - F 70 8/20/1941 MD rel", or items 23e or 28a-f show Examiner must be notified at ould be fliad within 72 hours effar deeth with the Merylend of Mantel Hygiene.

merked other then "neture!" 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Manchester 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2400 Mount Ventus Road #1 21102 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married 2 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify white th end Mantel Hygiene. 27 Is merked other then "neturel", treumetic event, the Medical Exa 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disability Benefits Mgr. U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Anthony Giudice Sr. Helen E. Jenkins . Pege 1 and 2 should b ment of Heelth end Mar tent: If Item 27 Is merk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon J. Giudice, wife 2400 Mount Ventus Road #1, Manchester, MD 21102 Item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Carroll Cremation 20c. Location - City or Town, State = 5 1 ☐ Burial 2 😾 Cremation 3 ☐ Removal from State Importent: If eny injury or once, 6/1/2012 Hampstead, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Lice 22. Name and Address of Facility M01072 Eline Funeral Home Main St. 934 Hampstead. MD 21074 uns 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **€**xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine ettending physicien end I for use es the buriel-trensit or Attending Physicien: The lew requires that the deeth cartificate be executed -ai ence that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 5 Other (specify) sete has been signed by the e pege 2 should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause o death? certificete has 1 ☐ Yes 2 ☐ No To the Hoepitel or Attending Physicien: Within 24 hours efter deeth.

To the Funerel Director: After this certific completaly filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes မြ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of o 30. Name and address of person who completed cause of death (Item 23a) (Type, Pript) Meyer 297A BALTIMORE MD ZIZIE Nexander Wolfe Enm 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 3 0 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ 254 AM Medical 4a. Facility Name (if not institution, give s **Examiner** 4c. County of Death 10904 pentia 1aidbore 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** ô **Director** 1 M 2 🗆 F Washington DC 28a-f show items 23a or 28a-f sho ner must be notified at County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? Funeral Ubent death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) other traumatic event, the Medical Examiner 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black. White, etc. 0 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 filed within 72 hours after 3 ☐ Widowed 4 ☐ Divorced 2 No 1 Yes Specify "natural" Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) id Mental Hygiene, marked other than Elementary/Secondary (0-12) College (1-4 or 5+) JOOR LON Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ William Wallace of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, P t) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ToyceGray 20a. Method of Disposition Upper Maribaroz Mother 10904 ME LUBERTIG Wa 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation.
4 ☐ Donation 5 ☐ Other (Specify) Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) ition 5 \_\_ 6-19-2012 Jando Ver Harmon 21. Sig kure 22. Name and Address of Facility WSency FUNERS Home 7527 old Hexandriz Ferry Rd Clinton IND 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ L. Dle disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buris Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Dav Year 2 🗆 No been signed by the a should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s Jas performed? Yes 2 No death? After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ◯ No Be 26. Place of Death (Check only one) Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature a 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 20b per fh g929 7-6-12 vt
State of Maryland 7 Department of Health and Mental Hygiene 20 | 2 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ D2 012 June 13, 10:13 A M James Henry Green Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Hours Director 224-22-6079 1 XM 2 🗆 F 86 Yrs April 17, 1926 Usual Residence of Decede Virginia or items 23a or 28a-f show 10a. State 10b. County the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic security. Funeral 5904 Sellner Lane 20735 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Enlisted Military Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Chris Green Sr. Annie Hudson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Wilder - Niece 5904 Sellner Lane Clinton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington
National Cemetery Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 8-1-2012 4 ☐ Donation 5 ☐ Other (Specify) <u>Arlington. Virginia</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. John T. Staum M00560 4001 Benning Road NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, lay, leading to immedicause. Enter Underlying Cause (Disease or injury qualto for as a consequence of burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for 5 Other (specify) Month 4 Pregnant a Pregnant at time of death Day Year detached the þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed Yes 2 death? 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No ပ္ Other: 1 Inpatient 2 NER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation Accident M 1 Yes 2 🗌 No 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State)

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 filled in by the funeral director, 24 hours after death Funeral Director: within 2 To the I

29a. Certifier (Check 2 Medical Examiner: On the best of my knowledge, death occion), one 3 Certifying Nurs. Practitioner: To the best of my knowledge, death occion, one 3 Certifying Nurs. Practitioner: To the best of my knowledge, death occion, one 3 Certifying Nurs. Practitioner: To the best of my knowledge, death occion, one 3 Certifying Nurs. Practitioner: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician: To the best of my knowledge, death occion, one 3 Certifying Physician	tion, in my opinion, death occurred at the time, date	and place and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, 1)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print ADOD HUMA 7503 SUI QUESTION OF THE STATE SIGNATURE 31. Date filed (Month, Day, Year) 32. Registrar's Signature	"Ad. Clinton, M	d 20735

and manner stated

ear!

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Harwood Anne Arundel Mandarin Hospice House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Feb 4, 1940 Days Hours Director 578 52 1083 Usual Residence of Dec 1 X M 2 □ F Washington, DC 72 er then "naturel", or items 23e or 28e-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Directo 1 ☐ Yes 2 🗓 No Prince George's Maryland Capitol Heights, 10f, Zip Code 10g. Citizen of What Country? Funeral 20743 United States 5234 Marlboro Pike within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 🛣 Married ፩ 1 ☐ Yes 2 √ No If Yes, Give X Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Hillside Drive In Theatre-Mgr. Entertainment 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental F item 27 is marked of ည treumetic Willie Thomas Gray Alice Amerreliss Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra S. Gray (Wife) 5234 Marlboro Pike, Capitol Heights, MD 20743 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 ò 1 Burial 2 XCremation 3 Removal from State Department of Importent: If eny Injury or once. 4 Donation '5 Other (Specify) Lee Crematory Tune 19, 2012 Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Signature of Funeral-Service Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Petal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1-Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA tospice 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

PO-N

Registrar
DHMH 17 Rev 06-2011

ame and address of pe

propleted cause of death (Item\_23a) (Type.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Greene 16<sup>Day</sup> Walter Matthew McKay 20 1º2 11:30 PM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death La Plata 4c. County of Death **Examiner** 1015 Suffolk Drive Charles 5. Social Security Number 6 Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 07/28/1923 578-26-3950 1 ₹ M 2 □ F Maryland Director 88 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho her must be notified at Director La Plata Charles MD Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 1015 Suffolk Drive 10f. Zip Code 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1A Yes 2 No If Yes, Give ' 4 3 - ' 4 6 Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 5 ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. "natural", Specify: White 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Andrews AFB Vehicle Maint. Foreman should be filed with and Mental Hygiens is marked other th 12 Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) Adie Gertrude McKay Stephen Philip Greene 19b. Mailing Address (Street and Number, or Rural Route Number, City or Town, State, Zip Code) 1015 Suffolk Drive, La Plata, MD 20646 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is it any injury or are Rose M. Greene/Wife 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Vets. Cem. JUNE Cheltenham, MD 4 Donation 5 Other (Specify) MD Vets. 28, 2012 22. Name and Address of Facility Raymond Funeral Svc. P.A. Signature of Euneral Service 5635 Washington Ave., La Plata, MD 20646 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one ca Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at Id be detached for Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy perform death? 2 🗌 No Yes 2 No To the Hospital or Attending Physician; 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 Yes 2 No Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after deau..

To the Funeral Director, After this and amount of the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred Certificate: 1 📈 Natural 5 Pending work 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical etrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie

State Registrar JUN 29 2012

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completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 8.00 AM Renda Galbraith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 10 Midship Drive Berlin Worcester If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F Months Days Hours Min FEBnth 1884, Year 940 184-30-1178 Pennsylvania 72 Director Usual Residence of Decedent perrift. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show miury or other traumatic event, the Medical Examiner must be notified at anne. 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 🗌 Yes 2 💢 No Worcester Berlin Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10 Midship Drive 21811 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) life. DO NOT use retired) College (1-4 or 5+) Clerical Air Freight Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Dallas Savage Ella Clough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur J. Galbraith/Husband 10 Midship Drive, Berlin, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Donation 5 Other (Specify) Gracelawn Memorial Park 2012 New Castle, DE 21. Sign ure of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final DIDMYD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnar-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death 1 Urknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 0 Ro 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No ျာ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Injury Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined

end

29a. Certifier

(Check

only one

29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009 1300

32. Registrar's Signatur

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated,

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month. Dav. Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death p 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Fairley Hurley June 9, 2012 3;55 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico 5786 Homestead St. Salisbury If Under 1 Year If Under 24 Hrs. Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth (Month, Day, Year) Days Hours Min. Director 407-46-0087 1 X M 2 - F 75 02/11/1937 Kentucky Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or items 23a or 28a-f show eny Injury or other traumatic event, the Markeal Examiner must be notified at. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Wicomico Salisbury Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 21801 USA 5786 Homestead St. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 X Yes 2 No Army Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Divorced 4 Divorced Koreā Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Auto Body Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Cora Pugh Nealy Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5786 Homestead St., Salisbury, MD 21801 Barbara Hurley /Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter), crematory or other place)
Springhill Memory
Gardens 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗋 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/13/2012 Hebron, MD Signature of Funeral Service Licensee <sup>2</sup>HOTIOWAY Tufferal Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 17 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CFSP Approximate Interval Betwee Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ CANCER LUNG Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): this certificate has been signed by the attending physician and rai director, page 2 should be detached for use es the burlal-transit The law requires that the death certificete be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 No ours after death. erel Director: After this certifica filled in by the funeral director, or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) é Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital o within 24 hours af To the Funerel Di completely filled in Medical 29a. Certifier 1 📡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0050929 06.12,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14055 DIVISION ST SALISBURY MD 21804 Madarana ewis 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 2012 12:25 p.\m. May 30 Helen Virginia 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours Min. (Month, Dav. Year) 214-32-8027 1 □ M 2 🗓 F 78 12/29/1933 Maryland Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No Maryland | St. Mary's Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46386 Fletcher Court 20653 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify: Specify: 3 X Widowed 4 Divorced Year or Dates White Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Vernon Wathen Anna Mae Yates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kim Austin/Daughter 47802 Kittamaquund Lane, Lexington Park, MD 20653 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 06/01/2012 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield 22955 Hollywood Road, Leonardtown, MD M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I Year Immediate Cause (Final Metastatic Carcinoma, Unknown Primary disease or condition Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery

Year

2 No

Hospice

1 Yes

May 31.

2012

Physician/ Medical Examiner

> burial-transit and

signed by

has

requires that the death certificate be executed

Box 68760

P.0.

Division of Vital Records,

Hospital or Attending Physician: The law

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within 24 hours a

State Registrar

10a. State

Director

Funeral

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Physician/

Medical

**Examiner** 

Funeral

Director

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ral", or items 23a or 28a-f shore Examiner must be notified at

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ntal Hygiene. ed other than "natura event, the Medical E:

and Mental Hygie is marked other

Department of Health and Ment. Important: If item 27 is marked any Injury or other.

filed within 72 hours after death

Baltimore, Maryland 21215-0036

physician s the burial Physician/Medical ettending pl Completed by funeral director, page 2 should Be ၉ Certificate: filled in by the

29a. Certifier

29b. Signature

resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 X No Month Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) XNatural 5 🔲 Pending injury 1 Yes 2 No M Investigation ∠ Accident 6 Could not be 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

31. Date filed (Month, Day, Year) State JUN 0 5 2012 Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Charles Benner,

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

20945 Great Mills Road, Great Mills, MD

29c. License number

D31563

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2012 Physician/ Barbara Rae Hamilton June 15,  $A^{\mathsf{M}}$ 3:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Shores Nursing Center St. Mary's Lexington Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 04/11/1932 Director 579-40-5543 80 Washington. Usual Residence of Decedent or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Funeral Director 1 ☐ Yes 2 🔀 No Maryland Calvert Lusby 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? "natural", or items 23a 858 San Mateo Trail 20657 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 H No Specify: Specify: White 3 Midowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Food Service Manager School Cafateria Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Raymond Albert Evans Dorothy Virginia Donaldson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Lee Neff / Daughter 858 San Mateo Trail, Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 4 Cremation 3 Removal from State 06/15/12 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, Virginia Signature of Funeral Service Licensee Rausch Funeral Home, P.A. 22. Name and Address of Facility P.O. Box 600, Lusby, MD 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each like Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed Yes 2 N 1 🗌 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Other: 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 5 Pending 2 🗌 No Investigation Could not be Accident in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completed fi (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) June 15, 2012

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nader Tavakoli

31. Date filed (Month, Day

D41978

12200 Annapolis Road, Suite 228, Glenn Dale, MD 20769

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ James Walter Hoagland 2012 June 2:58 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Berlin Nursing & Rehab. Center Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Sex ¥∏ M 2 □ F Hours 7 4 19 26 579 40 3057 Washington DC 85 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Ocean City Worcester 1X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3102 Anchorage Way 21842 USA 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 ☑ Yes 2 ☐ No If Yes, Give Navy Year or Dates. James and 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Giant Foods Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Robert Louis Hoagland Caroline Tupper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hoagland 3102 <u>Sara Hoagland (wife)</u> Anchorage Way Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State First State Crem. 6/14/12 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Athersclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Month Day Year Pregnant at time of death signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe After this certificate 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 **X**No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 5 Pending within 24 hours area. \_\_.

To the Funeral Director: Aftremental Director: Aftremental Director: Aftremental filled in by the fur Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or e 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) R 135131 June 14, 2012

βA 8+1 State

Registrar

DHMH 17 Rev 7/2009

21811

Pennie Savage, CRNP, 9715 Healthway Dr, Berlin, MD

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Physician/ Alice Jane Haines  $\mathbf{A}^{\mathsf{M}}$ June 4 6:44 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospice Dove House Westminster Carroll . Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs, last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Hours (Month, Day, Year) 178-22-7796 Director 1 M 2 M 1 82 1929 Maryland Sept. 16, 28a-f show 10a. State 10d. Inside City Limits at 10c. City, Town or Location Director must be notified 1 Yes 2 No MD Carroll Westminster 10f. Zip Code o 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 1636 Exeter Road 21157 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc . or 1 Never Married 2 Married Yes 2 No Yes, Give by Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Produce Clerk Food Market Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Edgar Loque Harriet Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if Health a Edward T. Haines - husband | 1636 Exeter Rd. Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 s Department of H Important: If ite 5 1 Burial 2 Cremation 3 Removal from State Pleasant Valley Cem. 6/7/2012 Westminster, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw F.H. any Westminster, MD 21157 Willis St. 23a. Part . Enter the disease, or complications shock, or heart failure. List only one cause Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, Interval Between Onset and Death 10 Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, eaching to in redicte cause. Enter Underlying Examine Эм to (слав в повверниваней) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): physician s the buria Physician/Medical Division of Vital Records, P.O. Box 68760 nding p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant. 23d. Date of delivery in the past 12 month ò Month Day Year 5 Other (specify) Pregnant at time of death ed by the at detached for 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of Was an has autopsy performed death? this certificate 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital WPATIEN 2 1100 1 Inpatient 2 ER/Outpatient 3 DOA 욘 1 Yes 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending death. Accident Investigation Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined nin 24 hours after the Funeral Dire npletely filled in b Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b, Signatu cause of death (Item 23a) (Type, Print) WESTMINSTER Cente

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June June 15 Ha11 10:16 PM Susan Swann Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Solomons Nursing Center Solomons Calvert Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗓 F Months Hours Min 1070974946 217-46-6532 Marvland 65 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3467 Chanevville Road 20736 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rici Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker be filed v Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Swann Herbert Harvey traumatic Haze1 Mae Armiger permit. Page 1 and 2 should b Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Homer W. Hall, husband 3467 Chaneyville Road, Owings, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Smithville Cemetery |06/29/2012 4 Donation 5 Other (Specify) Dunkirk, MD Si natur of Funeral Service Licen Rausch Funeral Home, P.A. 22. Name and Address of Facility any 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. Interval Between Immediate Cause (Fina Onset and Death Physician/ malignant neoplasm of brain disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 yes 2X 1 ☐ Yes 2 ☐ No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 🗶 No 1 Yes မြ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of Certificate: 28c. Injury at work?
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State Registrar

ARW

30. Name and address

31. Date filed (Month, Day,

Prince

who completed cause of death (Item 23a) (Type, Print)

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 2012 Joyce L. Hines 1615 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth Hours (Month, Day, Year) **Director** 577-56-5373 1 🗆 M 2 🛣 F 70 10/09/1941 Washington, DC 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 900 G Street, NE 20002 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. þ Yes 2 No Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates Black event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Machinist Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental F other traumatic Ethel Parker Richard Watts and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Appleseed Lane Carl Young/Son Gaithersburg, MD 20878 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ot Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) Lincoln Cemetery 06/22/2012 Brentwood, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home Chea 3401 Bladensburg Road Brentwood, MD 20722 23a. Part 1. Chter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Cardiopulmonary Arrest Medical resulting in death) Examiner Sequentially list conditions Gastrointesinal Bleeding Examine One to for each dichardments off If any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events NSTEMI Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be Acute Stroke 68760 the g phys IF FEMALE use 23c. If yes, outcome of pregnancy
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1 Yes 2 No for Month Day Year Pregnant at time of death ed by the detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cholangio Carcinoma - Metastatic Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? Yes 2 N To the Hospital or Attending Physician: The 2 🗆 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Hospital Other: မ 1 🗋 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending injury after death. Director: Af Accident Investigation 1 Yes 2 No the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License number

Registrar

DHMH 17 Rev 06-2011

1500 Forest Glen Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<u>Sirak Lemma</u>

D65069

Silver Spring, MD

06/13/2012

20910-1484

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23a. Part 1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiritiony arrest, shock or theart failure. List orky one cause one each line.  25a. Part 1. Enter the disease, or complications and caused the death. Do not enter the mode of dying, such as cardiac or respiritiony arrest, independent and shock or theart failure. List orky one cause one each line.  25a. Part 1. Enter the disease, or complications and according to the failure in the state of the failure. List orky one cause one each line.  25a. Part 1. Enter the disease, or complications and according to the failure in the state of the failure i	Page 1 nent of ant: If it		1 Burial 2 Cremation 3 Removal from Sta	te cemetery,	crematory or other place		15,	67/	n, State
Physician/ Medical Examiner  Provided Between the processor of the process	permit Depari Impor any in		Pernana S. Joh	mon :-	125 WI	1501 ST.	Keyswill	Home Va 23	?oj
Due to (or as a consequence of):    The part of the pa	Medical		shock, or heart failure. List only one cause on each I	ine.			espiratory arrest,	1	nterval Between
9 Unknown 1 Uper 1 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? 1 Uper 1 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? 1 Uper 2 Unknown 9 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Uper 2 Unknown 24a. Was an autopsy performed? 1 Uper 2 Unknown 9 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Uper 2 Unknown 9 Unknown 24a. Was an autopsy performed? 1 Uper 2 Unknown 9 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Uper 2 Unknown 9 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Uper 2 Unknown 1 Uper 2 Unknown 9 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Uper 2 Unknown 9 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Uper 2 Unknown 1 Uper 2 Unknow		g	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.						
The symmetric conditions contribute to the cause of death of the cause of the cause of death of the cause of the cause of death of the cause of t	ne death certifical / the attending ph ched for use as th	nysician/Med	23b. Was decedent pregnant in the past 12 months?  1 Ves 2 No  23c. If yes, outcon 1 Live Birt 4 Pregnan	h 2  Fetal death t at time of death		y			
26. Place of Death (Check only one)  27. Manner of Death  1 Natural 28a. Date of injury (Month, Day, Year)  28b. Time of injury at work? 2 Natural 2 Natical 2 Natural	uires that the signed by all die deta	þ		n but not resulting in t	he underlying cause giv	en in Part I.			
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30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)  Home Physicians 705 Pigital Drive Linthicam MD 21090	Physician: this certific al director,	To Be	examiner?  1  Yes 2 No Hospital: 1  Inp.		atient 3 DOA Othe	r: 4 Nursing Home	5 Residence		Assisted Go
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Home Physicians 705 Pigital Drive Linthicam MD 2/090	al or Attending s after death. I Director: After d in by the funer		1  Natural 5  Pending	Day, Year) inju njury - At home, farm	ry work'	Yes 2 No	i. Location (Street a	nd Number or Rural R	oute Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Home Physicians 705 Digital Drive Linthicam MD 21090	the Hospita hin 24 hours the Funeral upleted fille	Medical	(Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the control of the contr	f examination and/or in	ovestigation, in my opinion ge, death occurred at the	n, death occurred at the time, date and place, a	e time, date and place	e, and due to the cause	
30. Name and orderess of person who completed cause of death (Item 23a) (Type, Print)  Home Physicians 705 Pigital Drive Linthicom MD 2/090  Store 31. Date filed (Month, Day, Year)  32. Registrar's Signature	8		1 /h CFglu	rule V	3) 177	6451		6/8/19	y, Year)
		10	Home Physicians 70	5 Dig.	pe, Print)  Lital Dri	Ve LINI	thicom	MD.	21090

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>012</u> Physician/ Jennings Woodrow Hamilton June 12 12:35 p<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death LaPLata Charles 7425 Pomfret Road 5. Social Security Number Age (In yrs. last birthday, 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Months 1 XM 2 🗆 F Hours Maryland Min. March 26, Director 216-22-2687 1924 88 Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Maryland Charles LaPlata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7425 Pomfret Road 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White WII Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Painter U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Amanda Pickle Leroy Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley S. Hamilton Wife 7425 Pomfret Road, LaPlata, Md. 20646 permit. Page 1 and 2 Department of Healtl Important: If item 2' 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) June 15 Date 2012 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Waldorf, Maryland Trinity Memorial Gardens 21. Signature of Funeral Service Licental Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 23a. Part 1. Inter the dis shock, or hear failu Immediate Callse (Final disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ ad d disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): sician and burial-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as the t IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown ed by the a detached f 1 ☐ Yes 2 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ s been signe should be a Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital director Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes ္ဝ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending s after death. 1 🗌 Yes 2 🗌 No Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

Ba-16

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

03

Registrar's Signat

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31. Date filed (Monti

			For State Registrar	State of Mai		rtificate of	Death		g. No.	2 2091	
i	Dhariai		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month		3. Time of Death	
14	Physici /Medio		CARLTON LEROY	/ HILLIAR	D			JUNE 20		3:35 A M	
gail.	Examir	_	4a. Facility Name (If not institution, give				ERSTOWN		4c. County of Deal	th NGTON	
_			GOLDEN LIVING  5. Social Security Number 6. S		(In yrs. last birthday)	If Under 1 Year		Date of Birth			
ı	Funeral Director				74 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 3/14/193	Year) WES	thplace (State or Foreign ountry) T VIRGINIA	
	pu ,		Usual Residence of Decedent	1.	10- 01- T				,,,,,,		
	anyla ehov	2	10a. State 10b. County  WV BERK		I Oc. City, Town or Lo		TDC.			10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	the M	ecto	10e. Street and Number	KELEY	F A	LLING WAT	EK2	10	og. Citizen of What Co		
	with with	2	111 EMERALD DE	TVE		Toil. Zip Code	25419	10	USA	ountry?	
	deeth ms 2	nera	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto P	rfy Yes or No-	14. Race - Ame		
15-0036	within 72 hours after deeth with the Maryland ene. than "naturel", or Items 23s or 28s-f show he Medical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Forces?  VYYes 2 No fryes, Give Year or Dates:		If Yes, specify Cubi	an, Mexican, Puerto R Specify:	ican, etc.)	Black, White		
2 - -	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	dent's Usual Occup	ation during most of workin	9 1	6b. Kind of Business	/Industry	
77.7	vithin ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired ACKMAN	during most of working d)		RAILRO	<b>V</b> D	
N	filed v Hygie other f	ပ္ပိ	12 17. Father's Name (First, Middle, Last)		110	ACKMAN	18. Mother's Name	(First Middle M	Maiden Sumame)		
Maryland	id be ental ked o	To Be	HERMAN HILLIARD					RTURNER	,		
ary	shou ind M mar		19a, Informant's Name/Relationship (1	Type, Print)	19b. Maili	ng Address (Street	and Number or Rural			Zip Code)	
	and 2 selth a n 27 i		SHERRY ROURKE/DAL	JGHTER	1180	6 WICOMIC	O COURT, S	SMITHSBL	JRG, MD 21	783	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelth and Mental Hygiene. Important: if itsm 27 ie marked other than "naturel", or Items 23s or 28s-f ehow eny injury or other traumatic event, the Madical Examinar must be notified at once.		20a. Method of Disposition  X		20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place VIEW MEMORY GARDENS	JUNE 25 2012		oc. Location - City or MARTINSBU		
Balt	permit. Departrimporte eny inju		21. Signature of Funeral Service Licen	Feld	2:	Name and Addre		BOX 821,	327 W. KING	ST.,	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the	ne death. Do not en	ter the mode of dyin	ng, such as cardiac or	respiratory arre	st,	Approximate Interval Between	
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	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		De lana	0			
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Ī	ited insit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	out to (or as a	consequence or).					2	
ĵ.	exection and ial-tra	Examiner	resulting in death) Last	Due to (or as a	consequence of):						
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C. Box	The law requires thet the death certificate be executed to has been signed by the ettending physicien and bage 2 should be detached for use as the burtal-transit	by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown  5 Other (specify)					23d. Date of de Month	livery Day Year	
ري ح	res thet signed b	y Pr	Part II. Dther significant conditions	ontributing to death but	not resulting in the u	nderlying cause giv	ren in Part I.	23e. Did tob	acco use contribute to	the cause of death?	
ž	w require been sig should b		man	un m	Mou			1 ☐ Ye	s 2 No 3 P	robably 4 Onknown	
Vital Hecords,	e lawr has be ge 2 sh	Completed	0657	manie	lung	Disca	re	24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
E E		Con	Chr	me Col	145			perform	ned2   death?	2 □ No	
	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		o Oth	26. Place of Death				
ō	Phys ral di	5	1 Yes 2 10	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatie	IT 3LI DOA			nce 6 Other (Spe	ecify)	
0	Attending Physician: r death. ector: After this certific by the funeral director.	tion;	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Wor	k? Yes 2∐No		,, 33232		
Division	l or Attendi efter death. Director: A	Certificati	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	/- At home, farm, st	reet, factory, office	2	8f. Location (Str	eet and Number or R	ural Route Number,	
ā	rs efter al Dire	Cert	/	building, etc.	(Зреску)			City or Town,	, State)		
	To the Hospital or within 24 hours ette To the Funeral Direction completely filled in the Funeral birection of the Funeral birection in the funera	Medical	29a Certifier 1 Certifying Ph (Check only 2 Medical Examons)	ysician: To the best of niner: On the basis of e and manner state	xamination and/or in	h occurred at the the vestigation, in my o	ne date and cloce as pinion, death occurre	nd due to the nt d at the time, da	ute(t) and manner arte and place, and due	e to the cause(s)	
	To T To 1	Σ	29b. Signature and title of certified	1	1	29c Licens			d. Date signed (Mon		
	Mrs 1			+ 1		124	4990		tyne 20,	20,2	
	1 011		30. Name an Pres person who			Print) 11 La	appans o	ld Bi	onshow!	21713	
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 29 2012	22. Registrar	s Signature						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 05 **Physician** 10:47 A M Robert Lewis Immler 31 2012 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Longview Nursing Home Manchester Carroll If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 91 213-14-4174 MD 02/01/1921 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director Westminster MD Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 639 Hook Road 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1€ Yes 2 □ No WWII If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married 1 □Yes 2 No Specify: White 2 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Route Foreman Creamery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thelma Keyser Howard Milton Immler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Immler/wife 419 N. Queen St., Littlestown, PA 17340 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Krider's UCC Cemetery 06/04/2012 Westminster, MD 22. Name and Addres Printits Funeral Home and Chapel, PA Signature of Funeral Service Lig 21157 412 Washington Road, Westminster, MD 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Park disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? 2 🗆 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 🗌 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ANatural Injury 5 ☐ Pending

requires that the death certificate be executed and burial-trar Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: funeral director. After this To the Hospital or Attency within 24 hours after death To the Funeral Director;

attending physician for use as the burial cate has been signed by page 2 should be detack

**Funeral** 

Director

nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hyglene. ortant: If iten 27 is marked other than "natural", or items 23a or 28a-f show Injury or other tran matter and the transmitter ovent, it a fedical Exeminar mental and the profiled at th

permit. Page: Department o Important: If i any Injury or

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

29c. License number 29d. Date signed (Month, Day, Year) 037213 (Item 23a) (Type, Frinc) 30. Name and address of person who completed caus 2613

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month

29b. Signature and title of certifier

2 Accident

4 Homicide

(Check only

3 ☐ Suicide

29a. Certifier

Medical

investigation

determined

6 ☐ Could not be

Registrar's Signature 32

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Jacke

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :59 PM Medical 01 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Bal 505 If Under 1 Year If Under 24 Hrs. Numbe 8. Date of Birth (Month, Day, Year) Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 231-92-6608 **Director** 1 M 2 F 54 Dec. 8, 1957 Ohio Usual Residence of Decedent or 28a-f show notified at the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21061 343 Monticello Court United States permit. Page 1 and 2 should be filed within 72 hours after death \ Department of Health and Mental Hygiene. Important: I firem 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: African 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced <u>American</u> 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th Automobile Service Manager Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ William Francis Joyner Dorma Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon R. Joyner - Wife 343 Monticello Court Glen Burnie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State JuneDate 22. cemetery, crematory or other place)
Maryland
ational Cemetery ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National 2012 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. K/1/82 M01605 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 25 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Dire to (or as a consequence of) cause. Enter Underlying Exami Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran-Due to (or as a consequence of): Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year signed by the at d be detached for Pregnant at time of death Yes 2 No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Completed Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 No 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: ျာ 1 Inpatient 2 5 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury ( (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident filled in by the Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the I 3 🗆 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certified Name and address of person who completed cause of death (Item 23a) (Type, Print) /ndr 31. Date filed (Month, Day, Year)

State

Registrar

32. Registrar's Signature

5 20

completely

State Registrar

29b. Signature and title of certifier

Zabiullah Ali, M.D.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 21, 2012

12-04427 Constance Krotzer

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2012 20914

		1- For State Registrar				rtificate of				Reg. No.	0	to the U.S.
Physicia		Decedent's Nan							2. Date of Dea		Year	3. Time of Death
Medical Exami	ner	Combea		aine Krot			l. Oit. Town	or Location of Do	Month June 12,			1021 hrs
		-	Regional Med	_	'')		Salisbury	or Localion of Di	eam		County of Death	1
Funeral		5. Social Security			ge (In yrs.	last birthday)	If Under 1 Ye	ear If Under 24	Hrs. 8. Date of B			thplace (State or
Director		534-16-	7128 1	M_2X_F	89	Yrs.	Months Da	ays Hours	Min. 7/1/.		Foreig	
		Usual Residence of	of Decedent	L								
w any		10a. State	10b. County			, Town or Location	on					10d. Inside City Limits
yland -f sho	to	MD 10e. Street and Nu	Worce	ster	Ве	erlin		<del> </del>				1 Yes 2 No
e Mar or 28a	irec			# <b>2 1 1 7</b>			10f. Zip Code			_	n of What Cou	ntry'?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	<b>Funeral Director</b>	1 Meado	w Dr.	# Z I I A  12. Was Deceder	nt Ever in U	.S. 13. Was		811 Hispanic Origin?	( Specify Yes or No		SA 4 Race - Ameri	can Indian, Black,
leath v	nue	1 Never Marri	ed 2 Marr	Armed Forces				an, Mexican, Pu			White, etc.	Jan Halan, Diasi,
after o	3 X Widowed 4 Divorced If Yes, Give Year or Dates:									pecify: Wh	nite	
hours				only highest grade co				eation (Give kind fe. DO NOT use		16b. Kin	d of Business/I	ndustry
36 in 72 than "	Completed	Elementary/Sec 12	ondary (0-12)	College (1-4 or	5+)	Head	Start	Teach	er	Ed	ucatio	on.
d with	E	17. Father's Name	(First, Middle, La	lst)		11000			ame (First, Middle,			
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hyggene. In 27 is marked other than numatic event, the Medical	Be	Ulysses McKiernan Jesse Smith										
21 hould hold Me is man	မှု			(Type, Print Gran					or Rural Route Nur			
MC and 2 signal and 2 signal and 27 signal a		Summer 20a. Method of Dis		igh/daugh	_	_						DE 19945
ore, of He of He				3 Removal from S	tate	Place of Disposit crematory or other	er place)		Date		cation - City or	
Baltimore, permit. Pages I ar pepartment of Hes Important: If ite		4 Donation 5 Other Specify: First State Crem. 6/14/2012 Millsh										
Bal permi Depar Impo		A Sun B. 1 1 100 Milliam Ch. Daville MD										
Physician	$\dashv$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
/Modical		failure. List on Immediate Cause (		a. Blunt Force He	ad Trau	ma						Between Onset and Death
Examiner	- 1	or condition resulti		Due to (or as a cons	sequence o	f):						
	<u>_</u>	Sequentially list co	fluitions,	b. Due to (or as a cons	sequence o	f)·						
	튑	cause. Enter Unde	erlying Cause	0								
ted Insit	Examine	events resulting in	•	Due to (or as a cons	equence o	f):						
lox 68760, eath certificate be executed a sttending physician and for use as the burial - transit	Medical	UNPENDED		AMENDED								
'60, ate be ohysici	Med .	IF FEMALE:		23c. If yes, outco	me of preg	nancy				23d, E	Date of delivery	
687 certific ding p		23b. Was decedent past 12 months		1 Live birth 4 Pregnant a	time of de	-41.	death 3	Ectopic pres	gnancy	М	onth D	ay Year
Box 687  e death certific  the attending p  ed for use as th	Physician/	1 Yes 2 🗸	No 9 Unkno		t time of de	oath 5 Othe	er (Specify)					ì
O. B at the d 1 by the tached		Part II. Other signi	ficant condition	s contributing to dear	h but not re	esulting in the un	derlying cause	given in Part I.	23e. Did to	bacco use	contribute to t	he cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly	P P				,				1 Yes	2 🗸 N	lo 3 Prob	ably 4 Unknown
v requ	Completed								24a, Was autop			opsy findings available empletion of cause of
Recc The lay	E								perfor	rmed? 2 ✔ No	death?	
Vital Rec ysician: The his certificate director, page	Be	25. Was case referrexaminer?	ed to medical				26.Plac	e of Death (Che	ck only one)			
Physic r this al dire	ပ	1 🗸 Yes	2 No			ER/Outpatient			sing Home 5			
Sion of Attending Phar death.	티	27. Manner of Death	n 5 Pending	28a. Date of Inji (Month, Day) Jun 12, 2012	ury (ear)	28b. Time of Inj 0200 hrs	·   _ :	ury at Work? Yes 2 ✓ No	28d. Describe t Subject fell	now injury	occurred	
Sional Attentar deat rector by the	<u> </u>	2 🗹 Accident	Investiga	28e Place of Ir	niury - At ho	ome, farm, street,			28f Location (9	Street and	Number or Pur	al Route Number, City
Division ospital or Attent hours after death nueral Director: y filled in by the	Certification:	3 Suicide 4 Homicide	6 Could no determin	ot be		ving Center	ractory, office	Danialing, Oct.	or Town, S 7 Meadow Str	tate)		ar reduce realiser, only
Hosp 24 hou Funer		29a. Certifier (Check only 1		clan: To the best of m	y knowledg	ge, death occurre						
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical			er: On the basis of exa and manner stated.								
E > F 0	Ž	29b. Signature and	title of certifier	X	112		29c. Licen				e signed (Mon	th, Day, Year)
		IN	1	///	VII		O.C.	.M.E.		June 1	13, 2012	
n1/a		30. Name and addre Russell Alex		Assistant Medic			/ Baltimore	Street Rait	imore, MD 212	223		
JH 6 Sta	te	31. Date filed (Mont		32. Redistra		re .		, oneon, Dall	OCANE			
Registr		,	111M 1 5	2012		1 6-	Kel					

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner m	by F	3 Widowed 4 X Divorced If Yes, Give Year or Dates:	1 Yes	2 X No specify:		Specify: W1	nite						
THE STATE OF				ual Occupation (Give I working life, DO NOT		16b. Kind of Business/	Industry (Industry						
13	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	daming most of	working mo. Borton	aso remed,								
Med th	Completed	10	Tree Clim			Tree Care	e Co.						
4 4		17. Father's Name (First, Middle, Last)		18.Mother	s Name (First, Middle, N	faiden Surname)							
vent,	Be	Tommy Gray Kyger Sr.			ence Marie								
is my	မ	19a. Informant's Name/Relationship (Type, Print )				per, City or Town, State, Zip Code)							
Page 1		Florence Kyger/ Mother	<del></del>		vre de Gra								
e fe			lace of Disposition ( ematory or other pla		Date 6/15/2012	20c. Location - City or	Town, State						
벁			r. Foard	Funeral Ho		Rising Su	n, MD						
1 E		21. Signature of Funeral Service Licensee			eral Home,								
直道		trale. My to			Rising S		1						
cian		23a. Part I. Enter the disease, or complications that caused the death.					Approximate Interval						
fical		failure. List only one cause on each line. Immediate Cause (Final disease a, Torso Injuríes					Between Onset and Death						
iner		or condition resulting in death)  Due to (or as a consequence of)	:										
		Sequentially list conditions, b											
	ē	if any, leading to immediate cause. Enter Underlying Cause  Due to (or as a consequence of)	:										
	Examiner	(Discase or injury that initiated											
nsit ,		events resulting in deathy East	•										
n and	Physician/Medical	d.											
ysicia	<u>ē</u>	IF FEMALE: 23d Pate of delivery											
ng ph	죌	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year											
use a	흥	past 12 months?  4 Pregnant at time of dea											
he at	S/L	1 Yes 2 No 9 Unknown 9 Unknown											
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Funeral Director: After this certificate has been signed by the attending physician and rely filted in by the funeral director, page 2 should be detached for use as the burial - transit	d by				1 Yes	2 No 3 Prot	oably 4 Unknown						
peen	Completed	f.			24a. Was a autops		topsy findings available completion of cause of						
e has	밁				perform	ned? death?							
ificat r, pag		25. Was case referred to medical		26.Place of Death (	1 Yes 2	!No1	es 2 No						
s cert	8	examiner? Hospital: 1 Invatigat 2 of 5	P/Outpatient 3	Othor	Nursing Home 5 F	Residence 6 Other							
er thi	유	Tes 2 No	28b. Time of Injury	28c. Injury at Work?		ow injury occurred	-						
Full F	5	(Month Day Year)	1141 hrs	1 ✓ Yes 2	Subject fall for								
by th	盲	2 Accident Investigation 28e. Place of Injury - At hor	ne form street fact			troot and Number of Pu	ural Doute Number City						
A in	Certification	Suicide Could not be		ory, onice building, etc	or Town, St	treet and Number or Ru ate)	rai Route Number, City						
y fille	ပီ	4 Homicide				oad, Bel Air, MD							
be Fi	Sa	Check only (Check only one) 2  Medical Examiner: On the basis of examination and											
To the I	Medica	and manner stated.  29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo)							
		25b. Signature and trye of certifier				120	nin, Day, rear)						
	Į	TWI I		O.C.M.E.		June 10, 2012							
		30. Name and address of person who completed cause of death (Item 2		0 0	MD 04000								
		Jack Titus MD. Deputy Chief Medical Examiner		nore Street, Baltir	Tiore, MD 21223								
		31. Date filed (Month Day Year) 32. Registrar's Signature	1. Sank										
egist		Jon 12 2012 Three 1	a. pour										
ev 1/20	001	****	ORIGINAL			OCME							

20915

3. Time of Death

1255 hrs

10d. Inside City Limits

1 X Yes 2 No

Foreign Country)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Mar	-		of Health a of Death		al Hygien Reg. N	2010	20916
	Physici	an	Decedent's Name (First, Middle, Last     VALERIE VIVIAN	KENDRICK						ay Year 2 201	
	/Medic Examin		4a. Facility Name (If not institution, give		· · · · · · · · · · · · · · · · · · ·	4b. City, Tov	vn, or Location of			c. County of Dea	
	LAGIIIII	CI	1001 Spring St.,#8	325		SILVER	R SPRING	3	MO	ONTGOMER	Y
	Funeral		5. Social Security Number 6. S	ex 7. Age (	In yrs. last birthday) 57 Yrs.	If Under 1 Y Months Da	ear If Under ays Hours		te of Birth onth, Day, Yea	r) 9. Bir	thplace (State or Foreign ountry)
	Director		Usual Residence of Decedent	A	) / His.			2-2	6-1955		F.D.
	yland how		10a. State 10b. County	1	0c. City, Town or Lo	ocation					10d. Inside City Limits
	a Mar	Director	MD MONTGOME	ERY	SILVER S						X□Yes 2□No
	with th		10e. Street and Number			10f. Zip Co				Citizen of What C	ountry?
	ns 23	Funeral	1001 SPRING STREE	ET,#825 12. Was Decedent Eve	er in U.S. 13.	20910 Was Decedent	of Hispanic Ori	igin? (Specify Ye	US_ es or No-	14. Race - Am	
9	or Iter	Fun	1 XNever Married 2 ☐ Married	Armed Forces?  1 Yes 2 No If Yes, Give	ì	lfYes, specify 1☐Yes 24☐		n, Puerto Rican,	etc.)	Black, Whi	
003	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-1 show Ite Madical Ever in er reast the multified at	d by	3 Widowed 4 Divorced	Year or Dates:					105		
5	in 72 in 72 in at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual O kind of work d DO NOT use n	one during mos	it of working	160.	Kind of Business	undustry
212	d with giene.	mo;	Elementary/Secondary (0-12)	College (1-4or 5+)	SELF	EMPLOYE	ED		] ]	PRIVATE	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Exercities in a rutified at ance.	To Be C	17. Father's Name (First, Middle, Last) THOMAS KENDRICK					er's Name <i>(First,</i> Z GARY	Middle, Maide	en Sumame)	
ary	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (St	reet and Number	er or Rural Route	e Number, City	or Town, State,	Zip Code)
	and 2 ealth m 27 her tra		THOMAS KENDRICK,					ET, TEMPL		Location - City o	
20	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	memoval nom State	20b. Place of Dispo cemetery, crea RIVERDAL CREMATOR	matory or other E PARK	r place)	6-19-12		VERDALE,	
Baltimore,	artme ortant injury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licen</li> </ul>				ddress of Facili	y POPE	FIINERAI	L HOMES,	P.A.
B	permit. Departr Importa any inji		Charles E.	yours	701			1012		LLE, MD	
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)		ARIAN CAN		f dying, such as	cardiac or respi	ratory arrest,		Approximate Interval Between Onset and Death
	Examiner		Constitution and distance	h	, on 130 quoi 100 or j.						
	sit ad	Iner	Sequentially list conditions, Tary leading to mendata cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	cons-quence of):						
	xecute and II-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):						
760,	ate be executed hysician and the burial-transit	calE		d							
89	tificate ng phy as the		Tue service I								
Вох	es that the death certifica igned by the attending ph be detached for use as tt	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	⊒Ectopic pregn				23d. Date of de Month	olivery Day Year
0	the de	ysic	1 □ Yes 2 ☑No 9 □ Unknown	4⊡Pregnant at tin 9⊡Unknown	ne of death 51	Other (specif	y)				
Δ.	s that ned by e deta	by Ph	Part II. Other significant conditions of	ontributing to death but i	not resulting in the u	inderlying caus	e given in Part I	i. 23	3e. Did tobacco	use contribute	to the cause of death?
ğ	w require been sig should b	ted b							1 🗌 Yes	2 <b>X</b> No 3 ☐ F	robably 4 Unknown
Division of Vital Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed						24	ta. Was an autopsy performed?	prior to	utopsy findings available completion of cause of
<u>e</u>	ding Physician: The lav.n.		25. Was case referred to medical				26 Place	1 [ e of Death (Chec	☐ Yes 2 🔀 N	1 ☐ Ye	s 2 <del>X</del> No
$\geq$	ysicia is cert directe	To Be	examiner? 1 tt Yes 2 □ No	Hospital: 1  Inpatient	2 ER/Outpatie	nt 3 DOA	Other			6 ☐Other (Sp	ecify)
U O	ng Ph lifer th Ineral		27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	/ear) 28b. Time o		Injury at Work?		escribe how in	jury occurred	
<u>s</u>	Attending Physician: r death. ector: After this certific. by the funeral director.	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		- At home, farm, st	M reet factory of	1 ☐ Yes 2 ☐		cation (Street	and Number or F	Rural Route Number,
<u>≥</u>	in Life	Certification:	4 Homicide determined	building, etc.	(Specify)	reet, ractory, or	1100		ty or Town, Sta		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of a niner: On the basis of e and manner state	xamination and/or in	h occurred at to vestigation, in	he time, date ar my opinion, dea	nd place, and du ath occurred at th	e to the cause he time, date a	(s) and manner a and place, and du	is stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Li	icense number		29d. [	Date signed (Mor	nth, Day, Year)
	5		1	2		DOC	64983		(	1/18/2	2012
	11		30. Name and address of person who				11000	TIME C	DDTNC	MD 0000	12
	Sta	to	KASHIF FIROZVI, N	2 Registrar's	s Signature		#200, S	SILVER S	PKING,	MD 2090	14
	Registi		JUN 1 9 2012	Ceneral S.	parke						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 56AM CAROLYN BEATRICE KING MINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death CIVISTA LA PLATA CHARLES MEDICAL CENTER If Under 1 Year 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Mir 579-62-1167 Director 1 □ M 2 □XF 65 08-15-1946 DC Usual Residence of Dec 28a-f show within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD CHARLES WALDORF 1 X Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral items 23a 2203 ELGIN COURT 20602 US 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. If Yes, Give Year or Dates Specify: BLACK "natural", Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) nand Mental Hygien RESIDENTIAL COORDINATOR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P GEORGE A. RANDALL CAROLYN B. WORSLEY Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important; If item 27 any injury or other tra KEVIN D. KING/SON 2203 ELGIN COURT, WALDORF, MD 20602 Baltimore. JUNE 19, 2012 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State RIVERDALE PARK CREMATORY RIVERDALE, MD 4 Donation 5 Other (Specific ure of Funeral Service L 22. Name and Address of Facility POPE FUNERAL HOMES, P.A. 5538 MARLBORO PIKE, FORESTVILLE, MD 20747 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 month Day Pregnant at time of death signed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform certificate 2 No 1 TYes 2 🗌 No ☐ Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital 1 Tyes Other: 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No thours after death.

uneral Director; A
ely filled in by the fu Accident
Suicide Investigation 6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 2012

Registrar DHMH 17 Rev 06-2011

State

0

CAR

M

BLVD SUITE B.
GLEN BURNIE, MD

21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UDHAK

EVATHI

32. Registrar's Signature

1346 hrs

10d. Inside City Limits

1xx Yes 2 ☐ No

Country)

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Baltimore, MD 21 pernit. Pages I and 2 should Department of Health and Mee Important: If item 27 is man injury or other traumatic ev	-	Daniel Kapaska II/son	32	284 Westda	le Ct.	Waldo:	rf, MD 20	601				
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D. , ,		Zabiullah Ali, M.D. Assistant Medical Examir		vv. Baltimore Street	, Baitimore,	MD 21223						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death DOLORES YVONNE' Physician/ **KOCH** JUNE 20. <sup>D</sup>2012 Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 181-24-9182 Dec. 17, Year) 930 Pennsylvania 81 1 □ M 2 🗓 F Director 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits the Maryland must be notified at **Funeral Director** 28a-f Frederick Frederick Maryland 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? 23a 6894 Crabapple Court 21703 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. 9 þ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Lula M. Gottschall William L. Haley traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 6894 Crabapple Court, Frederick, Maryland 21703 William J. Koch / Husband other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 20a. Method of Disposition 20c. Location - City or Town, State June<sup>Da</sup>22. Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State 2012 Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fuperal Service Licensee Keeney and Bastord PA Funeral Home M01473 106 E. Church Street, Frederick, MD 21701 implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List of Approximate Interval Between Onset and Death Immediate Cause (Final EMBOLIC Ph\_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate Cause (Disease or injury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth ∠☐ Fregnant at time of death☐ Unknown in the past 12 months? Year Month Day detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ MYUCARPIAL INFARLTION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 🗆 No Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No မ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tes 2 No Investigation 6 Could not be ☐ Accider☐ Suicide Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated of cer 29b. Signature DUUG3498 6/20/12 WADHWA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State 29 2012 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day2 Derwin Kirk Lowe 640 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HIODAIOO MAINSL SA 6 | SBULL **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Days Months Hours Min. (Month, Day, Year) Director 303-82-3505 1**X** M 2 □ F 46 12-16-1965 Indiana ir than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits 1 Tes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29129 Santa-Fe Drive 21801 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Navy
If Yes, Give
Year or Dates 988 — 95 Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: SpecifyBlack Completed 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Menter traumatic event. Elementary/Secondary (0-12) College (1-4 or 5+) Ouality Control Inspector BaySys Technologies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Lowe Geraldine Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alisa Lowe/Daughter Santa-Fe Dr, Salisbury, MD 21801 29129 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place C 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Direct Cremation, 6-12-2012 Dover, DE Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Bennie Smith Funeral Home Salisbu Isabella St. and Bacon Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Naus Medical Due to (or as a Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated agents Examine Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the استنحا Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Defitying Physician. To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only (ne)

Registrar DHMH 17 Rev 06-2011

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31. Date filed (Month, Day, Year)

JUN

address of person who completed ca

Street

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29c. License number

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29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rosemary Lofgren 2:29A Medical 2012 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico At the Lo SPICE sburg ocial Security Number If Under 1 Year If Under 24 Mrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours 222-26-3517 Country) Director 1 🗆 M 2 🔀 F 69 05/10/1943 Delaware or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5784 Homestead St. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 and Mental Hygiene. is marked other than "natural", 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Sales Food Chain Be other traumatic event, filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Glen Mumford Dorothy West 19a. Informant's Name/Relationship (Type, Print) Rosemary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trau Mark A. Hudson/Son 5784 Homestead St., Salisbury, MD 21801 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Salisbury Crematory 4 Donation 5 Other (Specify) 6/12/2012 Salisbury, MD 21 Signature of Luneral Service Licer Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ CHRONIC OBSTRUC TNB disease or condition resulting in death) FULMONA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 pronths?
1 Yes 2/ No 5 Other (specify) Pregnant at time of death Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 🗆 Yes 1 ☐ Yes 2 <del>☐ No</del> To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: မှ 1 Yes 4105P142 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Spe 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Acciden 5 Pending Accident Investigation 1 🗌 Yes 2 🗌 No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 6 058400 Name and address of person who completed cause of death (Item 23a) (Type, Print) HELLAM 150 138 80 73 31. Date filed (Month, Day, Year) Signature State JUN Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <sup>Day</sup> 2012 Rita Augustus LoJacono 6:45 Рм June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 578-05-0622 Director 1 🗆 M 2 🛛 F 94 September 2, 1917 Washington, DC Usual Residence of Decedent 10c. City, Town or Location эегтіt. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director or 28a-f sl Marvland Prince George's Hyattsville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ö 10a. Citizen of What Country? must be 23a Funeral 5602 35th Place 20782 USA ral", or items a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, ori Completed by 1 Never Married 2 Married 2 🔀 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Specify: White 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home and Mental Hygiene. the Homemaker 12 event. th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Fitem 27 is marked or other traumatic even ည August P. Dorr Elizabeth Flaherty 19a. Informant's Name/Relationship (Type, Print) Thomas P. LoJacono / Son 5602 35th Place, Hyattsville, MD 20782 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Resurrection Cemetery 6/20/2012 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gash's Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician numoria disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed ours after death.

eral Director: After this certificate has been signed by the attending physician and filled in by the Internal director, page 2 should be detached for use as the burnal-transif that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Month Year Pregnant at time of death Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Grastro intestinal Bleed Division of Vital Records, 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementie autopsy performed' 1 Yes 2 No Yes 2 i 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital Funeral Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

15

Signature and title of certifier

31. Date filed (Month, Day, Year) JUN 1 8 2012

SABYAS NEUT WAR

juseuch has MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011 D0063703

PAREL,

29d. Date signed (Month, Day, Year)

6-16-12

AUENUE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month SSITER 03:32 AM Oi 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death EW NURSING HOME MT. AIRY MARYL DNA. CARROLL Sex 1 M 2 D F If Under 1 Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Aug 23, 1936 243-50-5798 No Carolina Director 75 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-1 31 Carroll Mt. Airy Maryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4101 Baltimore National Pike 21771 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Landscaping Landscaper 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Percy Lassiter Bessie Jane Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 Old Nat'l Pike Mt. Airy, MD 21771 Joan Hoff-Social Worker 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ott 20c. Location - City or Town, State 6/8/2012 ☐ Burial 2 Cremation 3 ☐ Removal from State So. Carroll Crematory Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate sheck, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ PERGNARY Acros 24 D. C. A.C. Medical Examiner Physician/Medical Examiner nding physician and use as the burial-transit Division of Vital Records, P.O. Box 68760

by Completed Be မြ Certificate: Medical

has

the Hospital or Attending Physician: Thin 24 hours after death.

the Funeral Director: After this certifica

completed filled in by To the Hospital within 24 hours a To the Funeral D

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

VELLANKIND

resulting in death)	CORCIOSAL DEVEL DISCH	2.D		Jean
resulting in death)	Due to (or as a consequence of):			/
	HYPERTENSION			Jany
Sequentially list conditions, if any handing to minimum to cause. Enter Underlying	Due to jor as a consecuence of:			,
Cause (Disease or linjury that initiated events				
resulting in death) Last	Due to (or as a consequence of):			-
	I			
IF FEMALE:				
23b. Was decedent pregnant 23	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of de	elivery
in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month	Day Year
9 🗆 Unknown	9 Unknown			
Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to	o the cause of death?
STROKES		1 🗆 Yes	2 ∕ No 3 ☐ F	Probably 4 🗆 Unknown
DEMENTIA		24a. Was an	24b. Were au	utopsy findings available
Degenerature	Joint disease	autopsy performed? 1 Yes 2	death?	completion of cause of
25. Was case referred to medical	26. Place of Death (Che	ck only one)		
1 Yes 2 No	ospital: 1	ome 5 Residence	6 Other (Spec	cify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work?	28d. Describe how inju		
2 Accident Investigation	M 1 ☐ Yes 2 ☐ No			
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a		ıral Route Number,
	building, etc. (Specify)	City or Town, Star	re)	
29a. Certifier Certifying Physic	ian: To the best of my knowledge, death occured at the time, date and place, a	nd due to the cause(s)	and manner as sta	ated.
(Check 2   Medical Examine only one) 3   Certifying Nurse	er: On the basis of examination and/or investigation, in my opinion, death occurred Practioner: To the best of my knowledge, death occurred at the time, date and pla	at the time, date and plac ice, and due to the cause	e, and due to the e(s) and manner as	cause(s) and manner state stated.

29c. License number

D. 30469

29d. Date signed (Month, Day, Year)

308 Columbia

June Ist 2012

, MD . 210245

State

Registrar

well

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signatur

was

8850

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of Health and Mental Hygiene											
			Registrar  1. Decedent's Name (First. Middle, Last)	eath	Reg. No. 2012 2092							
ı	Physicia Medic		Clara Jean Lambert				2. Date of Death Month June 7	Day	2 Year	3. Time of Death 2:20 p M		
	Examin	er	4a. Facility Name (if not institution, give street and number) 12431 Detour Road		4b. City, Town, or <b>Keym</b>			4c. County	y of Death Freder	ick		
	Funeral Director		212-38-4959 1 □ M 2 🕱 F	yrs. last birthday) 78 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) Apr 27			ace (State or Foreign Land		
	nd how	'n	Usual Residence of Decedent           10a. State         10b. County         10c	c. City, Town or Loc	ation				10	d. Inside City Limits		
	Maryla 28a-f s etified	Director	Maryland Frederick			Keyma	r			1 ☐ Yes 2 🗶 No		
	with the 1 23a or 2 ust be no	Funeral Di	10e. Street and Number 12431 Detour Road	-	10f. Zip Code	21757	10	g. Citizen of	What Count	ry?		
980	72 hours after death with the Maryland n "natural", or items 23a or 28a-f show fedical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Nowled 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates.	If Yes, specify Cuban, Mexican, Puerto			cify Yes or No- Rican, etc.)		ce - America ck, White, et			
5-0	2 hou "natu edical	plet	15. Decedent's Education (Specify only highest grade completed)		ent's Usual Occupa nd of work done du		na 1	6b. Kind of B	Business Indu	ustry		
2121	/ithin iene. rr thai	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	NOT use retired) Homemake	-		Ow	Own Home			
Maryland 21215-0036	e filed Ital Hy ed oth	To Be	17. Father's Name (First, Middle, Last)  Jacob Russell Stonesifer			18. Mother's Name	(First, Middle, Ma	iden Surnam	re)			
Mary	shou and is r		19a. Informant's Name/Relationship (Type, Print)  Jonathan D. Lambert, son	Route Number, C			ode)					
e, l	and 2 Health tern 2;	21757		- Charles								
Baltimore,	t. Pac tmer rtant vjury		0a. Method of Disposition       20b. Place of Disposition (Name of cemetery, crematory or other place)       Date       20c. Location - City or Town, State         4 □ Donation 5 □ Other (Specify)       Tother (Specify)       Keysville Union Cem.       6/11/2012       Keymar, MD									
Bal	permit. Pa Departmer Important any injury once,		21. Sinature of Funeral Service Licensee	ers-Durb , Taneyt	oraw F own, M	unera D 217	l Home 57					
	Medical Examiner  Street be executed by National Properties of the Parial-transit street by National Properties of the Par	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last  a. Due to (or as a con Control of Control	rital di nsequence of): re def	eficien	5 ofc	10#1.37	facto	nent a	hule life.		
. Box 68760		Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pre 1   Live Birth 2   4   Pregnant at time 9   Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				ate of deliver	/ lay Year		
s, P.O.	ires that the dea signed by the a Id be detached f	d by Pł	Part II. Other significant conditions contributing to death but no Factor I Leiden N			n in Part I.	23e. Did toba	-		cause of death?		
Division of Vital Records,	rsician: The law require s certificate has been si lirector, page 2 should b	omplete	· Primary Lypercoagul · HTN · Hypskalemia				24a. Was an autopsy performe	24b. 1	Were autops prior to com death?	y findings available pletion of cause of		
a F	sian: T	Be C	25. Was case referred to medical examiner?	~		ce of Death (Check	1 Yes 20	<b>∆</b> No	1  Yes 2	No		
f Vil	Physic this ce al dire	은	Hospital:	2 ER/Outpatient 28b. Time of		4 ☐ Nursing Hor	ne 5 Residend					
o uc	nding ath. ; After e funer	icate	1 Natural 5 ☐ Pending (Month, Day, Yeal 2 ☐ Accident Investigation	injury	28c. Injury : work? M 1 \(\sum \) Y	at es 2 □ No	8d. Describe how	injury occurre	ed			
)ivisio	al or Attending Physician; The lessafter death.  Director: After this certificate he din by the funeral director, page	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Spe	At home, farm, stree ecify)			8f. Location (Stree City or Town, S		er or Rural R	oute Number,		
_	To the Hospital or A within 24 hours after To the Funeral Direc completed filled in by	Medical	29a. Certifier   1   Certifying Physician: To the best of my kr (Check only one)   Certifying Nurse Practioner: To the best of the best of examination of the best	nation and/or investio	ation, in my opinion	death occurred at	he time, date and a	place, and due	e to the cause	e(s) and manner stated.		
_	To the comp		29b. Signature and the of certified	,	29c. License r	number	290	. Date signed	d (Month, Da			
D			THE YH VEUDE			0640		June 7,				
7	WHIL		30. Name and address of person who completed cause of death ( Panela J. Eaton CRNP.	A 420	2 gree	2 Valla	Rd. M	JUNGO	vie 1	n) 21770		
	Stat Registra	-	31. Date filed (Month, Day, Year) 1 2012 32. Registrar's Si	11 1	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland (Department of Health and Mental Hygiene State AMEND #26
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup>2012 Physician/ Frank James Lamot June 15 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4804 Orleans Court Waldorf Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 577-48-8827 Hours (Month, Day, Year) Director 1 🛛 M 2 🗆 F 73 Yrs. July 28, 1938 Riverdale, Maryland Usual Residence of Decedent 28a-f show 10c. City, Town or Location Director er than "natural", or items 23a or 28a-fs the Medical Examiner must be notified New Carrollton Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8119 Gavin Street 20784 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Al Hygiene,
Ad other the life. DO NOT use retired) Various Contractors Elementary/Secondary (0-12) College (1-4 or 5+) Painter 10 Be Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Lamot Beatrice Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene M. Jarrell / Daughter 4804 Orleans Court, Waldorf, MD 20601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 6/21/2012 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue 6 Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ ance disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month ed by the a detached f g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy perform Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home sidence 6X Other (Specify) After this e Hospital or Attending Physical Physical Physical Phous after death.

e Funeral Director: After this oletely filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No Natural 5 Pending Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Krishan Mathur

3. Time of Death

10d. Inside City Limits

Approximate Interval Between

Onset and Death

Year

Daughters esidence

1 X Yes 2 No

1:00

Рм

Registrar DHMH 17 Rev 06-2011

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death LEDBETTER Physician/ 0510AM JUNE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL THE JOHNS HOPKINS BALTIMORECITY If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth (Month, Day, Year) 1971 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 578-98-4255 Director 1 □ M 2 🗶 F 40 September 24, Washington, D.C. er then "neturel", or items 23e or 28e-f show the Medical Examinar must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Direct Temple Hills 1 X Yes 2 ☐ No Prince Georges Maryland| 10g. Citizen of What Country? Funeral United States 20748 4808 Henderson Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Was Decedent Even III S Army 1 12 Yes 2 No 1990 Year or Dates Nov 1990 Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 **Black** 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) el Hygiene. Fort George G. Meade Elementary/Secondary (0-12) College (1-4 or 5+) Laboratory Technician Army Base 6 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file end Mentel F is marked of Everee Lorraine Young Dwight Arlandis Johns permit. Page 1 end 2 should be Department of Health end Men Importent: If Item 27 is marke any injury or other treumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4808 Henderson Road; Temple Hills, Maryland 20748 Gary Amos Ledbetter (Husband) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition City or Town, State
Cheltenham, June 19,201 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Cheltenham Veterans Cemetery Maryland MO 421 2 mme and Address of Facility R. N. Horton Company Morticians, Ignature of Funeral Service Lee Inc.;600 Kennedy Street, N.W.; Washington, D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CARDIOPULMONARY Medical Due to (or as a consequence of) Examiner PULMONARY Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine ettending physician and for use as the burial-transit Cause (Disease or injury or Attending Physicien: The law requires that the death certificate be executed ERICARDIAL that initiated events resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 1 Ves 2 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of Sec autopsy performed?
Yes 2 \sum No death? After this certificete funeral director, pag 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No 1 Tyes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Matural Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funerel Director: A completely filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined Hospitel Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier RES-000 JUNE 10 2012 of person who completed cause of death (Item 23a) (Type, Print) 1800 ORLEANS ST BALTIMORE MD 21287 RASI WICKRAMASINGHE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 5 2012 Registrar

		Plea	ase Type or		Black In					-			Legible	<b>.</b>	
	•	1 - For State Registrar	State C	n iviai yiai	•		e of D		and i	vieritai my	, 0	g, No.	201	2	2092
Physicia	n/	1. Decedent's Name (First, Middle	,		··					2. Date of D Month		Day	Year		3. Time of Death
Medic	al	Marian Virgini 4a. Facility Name (if not institution				4h City	Town or	Location	of Dooth	06	1	1	2012		4:40 P M
Examin	er	Washington Adve	-			4b. City, Town, or Location of Death  Takoma Park						4c. County of Death Montgomery			
Funeral Director		5. Social Security Number 577–22–2353	6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 91	last birthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min,	8. Date of Bi	av. Ye	ear)	g. Bi	rthpla ountry	
		Usual Residence of Decedent			113.					02/15/	192	21	Ma	ry1	and
permit. Fage 1 and 2 should be littled within 72 hours after death with the Maryland appartment of Health and Mantal Hyglene. Important: If item 27 is marked other than "natural", or items 29a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director	DC 10b. County None			ity, Town or Loc shingto:									100	I. Inside City Limits  1XXYes 2 \( \text{No} \)
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ns 23¢ must l	Funeral	825 50th Place					0019					JSA			
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and Me is mar		19a. Informant's Name/Relationsh	hip (Type, Print)		19b. Mailing	g Address	s (Street a				er, Ci	ity or To	own, State, Z	ip Cod	de)
ling 2 state tealth im 27 her tra		Donald Paige/Grandson 301 Prairie Court Upper Marlboro, MD 20774												4	
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h, i i n Medical	8 1/2	23a. Part 1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	only one cause on ea	aused the dea	n feui	luve	-	, such as	cardiac d	or respiratory a	rrest,			lr	pproximate Iterval Between Inset and Death
Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):													
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within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 fnonths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Birth 2 ☐ Fet nant at time of	tal death 3 🗌	Ectopic   Other (sp	pregnancy oecify)	/				23	d. Date of de Month	elivery Da	ay Year
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een sig										1 🗆	Yes	2			oly 4 🗆 Unknown
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rtificat		25. Was case referred to medical examiner?					26. Pla	ce of Deat	h (Check	1 ∐ Yes conly one)	2 L	No	1 ∐ Ye	s 21	No
this ce	욘	1 Yes 2 No			ER/Outpatient			4 □ Nu	rsing Ho	me 5 Resi	idenc	e 6 🗆	Other (Spec	cify)	
th. ; After e funer	cate	27. Manner of Death  1	9	h, Day, Year)	28b. Time of injury	M 2	8c. Injury: work? 1 🔲 Y			28d, Describe	how i	injury o	ccurred		
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24 hours Funeral leted filled	Medical	(Check 2 Medical E	Physician: To the be xaminer: On the basi	s of examination	on and/or investig	gation, in	my opinion	, death oc	curred at	the time, date :	and p	lace, ar	nd due to the	cause	(s) and manner stated.
within To the		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)													
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4.		30. Name and address of person v	who completed cause	of death (Iten	m 23a) (Type, Pri	$\frac{Ly}{i}$	ali	Shaha over		Park	/	41	)		
Stat Registra	_	31, Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ature	JUN	1 921	U) L	Dense	and	Í.	10	nkal		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 6/14/12 #25 per MD FCHD TM State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Betty Ann Luhn Jume 20°12 6:27  $P_M$ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours **Director** 214-28-6149 1 □ M 2 🛣 F 78 Nov. 22, 1933 Maryland Usual Residence of Decedent or 28a-f show notified at 0a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick 1 Yes 2 X No Frederick o 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 6232 White Oak Drive 21701 United States hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify:White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th Seamstress Clothing Factory injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Ulysses L. Fisher Annie Ropp permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Luhn / Son 1496 Eden Drive, Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kesthaven
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State June  $\overset{\text{Date}}{12}$ , 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 2012 21. Signature neral Service Licensee 22. Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the diseas shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between st only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ 116 hnoi lmorr disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events e to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner: Hospital Other: မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 \( \subseteq \text{Yes} \quad 2 \subseteq \text{No} \) injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check 29b. Signature and title of certifier 29c. License number MDD 35106 7/20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Frint) Myung Hee Nam, 400 West 7th Street, Frederick, MD 21701 M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Billy Physician/ Allan McGinnis Month 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 544156419 PENINSULA BEGIONAL Medical HICOMICO If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Numbe Birthplace (State or Foreign Country) **Funeral** Min Days 498-30-1739 Director 1 🕱 M 2 🗆 F 82 12/15/1929 Missouri 28a-f show 10c. City, Town or Location at **Funeral Director** ıral", or items 23a or 28a-f sl Examiner must be notified 1 Yes 2 No Wicomico Mardela Springs Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21837 24925 Delmar Road permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Year or Date AirForce White "natural". 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. I other than " went, the Mex Elementary/Secondary (0-12) College (1-4 or 5+) Technician Military Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic even 2 Mabel May Greer George McGinnis gb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24925 Delmar Rd., Mardela Springs, MD 21837 19a. Informant's Name/Relationship (Type, Print) Charles R. McGinnis/son of Health 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 🗶 Cremation 3 🗀 Removal from State ± 6 Department o Important: If any injury or once. 6/11/2012 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Holloway Funeral Home Professional Association Signature of Funeral Service Licenses Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ASCIVO Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death should be detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 No Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed Yes 2 X No 1 Yes 2 No the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 X DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier соmpletely To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6/5/12 STIVE C. Com 100 Doc-iseigs

Registrar DHMH 17 Rev 06-2011

TH

State

VID

1665 Windbroke Br.

ar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

JAME A. CRUCK, MO

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Plea	se Type or P					<b>c. Ensure</b> lealth and			_	ble.	
		For State Registrar						ite of E		- Ivieritar i	Reg.	20	12	2093
Physicia Medio	cal	1. Decedent's Nam	Kef	alos		rtin	T					2012	Year	3. Time of Death 4:48 PM
Examin	er		ouse of	give street and number			Ве	thes				4c. County of	omery	
Funeral Director	Jr.	190–07–9( Usual Residence	057	6. Sex 1 □ M 2 🔯 F		95 Yrs.  ty, Town or Lo	Month	der 1 Year s Days	If Under 24 Hrs Hours Min.		Day, Yea		Penns	ace (State or Foreign y) <b>Sylvania</b> Id. Inside City Limits
the Maryla or 28a-f s be notified	I Direct	DC 10e. Street and Nur	nber		Wa	Washington 10f. Zip Code						Citizen of Wi		1 ☒ Yes 2 ☐ No
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral Director	4519 36  11. Marital Status  1  Never Marr  3  Wildowed		12. Was Deceder	?		Was Dec If Yes, sp	0008 edent of Hi ecify Cubar 2 X No	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or N o Rican, etc.)		14. Race Black Specify:	- America , White, et	n Indian, c.
within 72 hou giene. <b>er than "nat</b> <b>, the Medica</b>	e Completed	(Spe Elementary/Seco		t's Education It grade completed)  College (1-4 c	r 5+)	(Give life. D	reedent's Usual Occupation Ive kind of work done during most of working Parties DO NOT use retired)  retary					16b. Kind of Business/Industry  Real Estate		
d be filed fental Hy rrked oth tic event	To Be	17. Father's Name (							18. Mother's Na		lle, Maide	,		
nd 2 should lealth and M m 27 is ma her trauma		19a. Informant's Name/Relationship (Type, Print)  Eleni Martin / Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  9915 Brixton Lane Bethesda, MD 20817											ode)	
it. Page 1 a irtment of H irtant: If ite njury or oth		20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c.												
permit Depar Impor any in		Willis	ng K	Bugge		51	.30 W	liscor	nsin Ave	., NW,	Wash			20016
Physician/ Medical Examiner  purial-transit	al Examiner	23a. Part 1. Enter t shock, or heal Immediate Cause ( disease or condition resulting in death)  Sequentially list confirmed in the Gause Enter Under Cause (Disease or that initiated events resulting in death) I	rt failure. List or Final on inditions, inmediate riying injury s	a. Cerebr Due to (or a b. Hypert C. Due to (or a b. Due to (or	al Vas a consequence a consequ	scular uence of): uence of):		11.		or respiratory	arrest,	. *	1	Approximate nterval Between Onset and Death
ath certificate b attending physic for use as the b	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										y Day Year		
requires that the de- been signed by the s should be detached		Part II. Other signif		ns contributing to death	but not res	sulting in the u	ınderlying	g cause give	en in Part I.		_			cause of death?
:: The law re icate has be r, page 2 sh	Completed by	25. Was case referre								pe 1 □ Ye	as an topsy rformed? s 2 [X	pri de		y findings available pletion of cause of
Physician: 1 this certifica ral director, p	To Be	examiner? 1 ☐ Yes 2 🗽	<b>Z</b> No			ER/Outpatier	nt 3 🗆 I	Othe	r: 4 X Nursing I		sidence	6 Other	(Specify)	
Attending P er death. ector: After tl by the funers	Certificate:	27. Manner of Death  1 X Natural  2 Accident  3 Suicide	5 ☐ Pending Investiga 6 ☐ Could n	ation of he	lay, Year)	28b. Time of injury	М			28d. Describe				
pital or At burs after or eral Direc filled in by		4  Homicide	determir	28e. Place of I	etc. (Specif)	/)			data and place	City or T	own, Sta	ite)		oute Number,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check 2	Medical Ex X Certifying	aminer: On the basis of Nurse Practitioner: To	examinatio	n and/or invest	tigation, in death or	n my opinior	n, death occurred ne time, date and p	at the time, date	e and pla o the cau	ice, and due to	o the cause nner as sta	e(s) and manner stated. ited.
20		30. Name and addre	ess of person.	Ho completed cause of	death (Item	1 23a) (Type. F	Print)	R0960	)53		06	5/11/20		
Stat	e	Babette 31. Detailed (Mont	Pennay	C.R.N.P. 1	5245	Shady	Grov	e Roa	d Rockv	ille, M	D 20	850		
Registra	ar	- O	FAIL Y	many pa	1900	A. Car								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Physician/ Medical Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Mandrin Hospice House Harwood Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours (Month, Day, Year) 03/15/1932 340-40-5227 Director 1 M 2 XF 80 Wash., D.C. ir than "naturei", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director D.C. Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 417 Independence Ave., S.E. 20003 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14 Race - American Indian Black White etc þ 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: Completed 3 ☐ Widowed 4 🖾 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. 5 College (1-4 or 5+) Elementary/Secondary (0-12) Elementary School Teacher Education Be 17. Father's Name (First, Middle, Last) 1 end 2 should be filed of Health and Mental H 18. Mother's Name (First, Middle, Maiden Surname) is marked ဂ္ဂ Irving Sewall Beatrice Bundy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7902 Knollwood St., Brandywine, Md. Camille R. Robinson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or o cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cem. 06/22/12 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Henry S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 CC0316 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. Immediate Cause (Final set and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and for use as the burlal-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☑ No 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical funeral director, | <u>@</u> 26. Place of Death (Check only one) ᇛ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1. Natural 5 Pending 24 hours after death. Funeral Director: A 2 Accident 1 Yes 2 No Investigation 3 Suicide 6 Could not be à Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in Hospitai Medical To the Hosp within 24 hou To the Funel completely fi 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Name and address of person who of death (Item 23a) (Type, Print) State

Registrar DHMH 17 Rev 06-2011

of Vital

Division

Registrar

DHMH 17 Rev 06-2011

MA

K, Kickett 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

Westminster Mary

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9/0

32. Regi

Washingta

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2012 JUNE: MARVIN RILEY MULLENS 10:40 pM 21 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Hospital Elkton Cecil Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs, 8. Date of Birth 9. Birthplace (State or Foreign 234-58-9431 Months Days Hours April Day Ye West Virginia 1939 1X M 2 □ F 73 Yrs Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Cecil Elkton 1 Yes 2X No

Physician/ **Funeral** Director or 28a-f shov notified at Director 10e. Street and Number 10f. Zip Code ms 23a or must be r ò 10g. Citizen of What Country? Funeral 21921 U.S.A. 48 Augusta Dr. items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner ed Forces? Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married X Yes 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White If Yes, Give Year or Dates. Korea 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) . Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) Utility Supervisor Pipeline Construction 8 other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve 2 John Riley Mullens Lucy Ann Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Mullens (son) Chesapeake City, MD. 21915 88 Gour Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Kent Cremation Services 4 Dopation 5 Other (Specify) 6/22/12 Smyrna, DE. 22. Name and Address of Facility Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 whe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest leart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ neumoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) been signed by the atte should be detached for in the past 12 months? 2 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CANCER 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has death? 1 Yes 2 No Yes completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) D0062190 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21915

State

Shahnawaz Kahn, M.D.2533 Augustine Herman Hwy. Suite A, Chesapeake City, 32. Registrar 29

Registrar

12-04608 Lana Mostardi

amend #5 Per FH G940 6/20/2013 JH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2012 20935 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar				Ce	ertifica	ate of	Death					Reg. No		U	E	_ () )
Physici		1. Decedent's Name (I	First, Middle	e,Last)								2	. Date of De Month	ath Day	Yea	, ]	3. Time of D	
edical Exam	iner	_ Lana		Elai			osta	ardi					June 18,	2012	Tea	ı,	2340 h	rs
		4a. Facility Name (if n		_		ımber)		41	c. City, To		ocation of	Death			c. County o	of Death		
		Chicamuxen F	Road @	Willob	y Road				Marbur	У				_ ['	Charles			
Funeral		5. Social Security Nun 228-43-89	nber 96	6. Sex		7. Age (In yrs.	last birtl	hday)	If Under				8. Date of E	Birth (MM	/DD/YYYY	9. Birti Foreigi	nplace (State	e or
Director		200 43 07		1 M	2X F		30	Yrs.	Months	Days	Hours	Min.	10/2	9/1	981			VA :
		Usual Residence of De																
/ any		10a. State 10	b. County			·		or Locatio	n								10d. Inside	
and show	5	MD	Char	rles	5	1	Wal	dorf									1 Yes	2 X No
faryla 28a-f	Director	10e, Street and Number	er						10f. Zip C	ode			I	10g. Cit	izen of Wh	at Coun	try?	
vith the Maryland 138 or 28a-f show 1 2 notified at once,	늅	3058 He	athco	ote	Rd.				2	060	2		l	U	.S.A			
with ns 23 be no	Funeral	11. Marital Status		1		edent Ever in U	J.S.						ify Yes or N	lo-			an Indian, E	Black,
death r iter	un.	1 Never Married	2 Ma		Armed F	2 No		If Yes	s, specify	Juban, I	Mexican, I	Puerto Ri	can, etc.)		White	, etc.		
after	by F	3 Widowed	4 Dive	orced if	Yes, Give Year Dates:	ır 🛣		1 🗌 🗅	∕es 2∑	No	specify:				Specify:	Wh	ite	
ours A mi	ad k	15. Decedent's Educ		ify only	highest gra	de completed)		Decedent's						16b.	Kind of Bus	siness/Ir	dustry	
6 . 72 h	Completed	Elementary/Second	ary (0-12)		College (*	-4 or 5+)	] `	adming mo	O # O ! !!	ig inc. L	70 NOT 0	100100	-,					
Nethir	ınc	12					I	Home	make			-			wn H			
Hyg doth	ပ္	17. Father's Name (Fir Michael		Last) Stal	rđi					18			irst, Middle		Surname)			i
21215-0()36 nuld be filed within 7 Mental Hygiene. marked other thau c event, the Medica	Be C	19a. Informant's Name					140	Maritin -	A -d-d	<u> </u>		uth		Wis				
MD 21215-0()36 1 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. a 27 is marked other than "natural", or items 23a or 28a-f she unmatic event, the Medical Examiner must be notified at once.	To	Ruth L.				hor							alRouteNu , Wal					
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		1 X Burial 2		3 🗌	Removal fr	om State	cremato	ory or othe	r place)									
Fag ment tant:		4 Donation 5				H	eri										Mary.	
Baltimore, permit. Pages la Department of He Important: If ite injury or other to		21 Signature of Funer	al Service I	icensee		MO1	517					_						e P.A
		23a. Part I. Enter the d	100000					563	5 Wa	shi	ngt	on A	lve.,	La	Pla	ta,	M D .	20646
Physician //Medical		failure. List only				aused trie deat	n. Do no	t enter the	mode or c	iyirig, sc	ucri as car	diac or re	espiratory ai	rest, sn	ock, or nea	irt	Between (	Onset and
Examiner		Immediate Cause (Fin or condition resulting i			Itiple Inj												De	ath
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	ē	Sequentially list condit if any, leading to imme	ediate	Due	e to (or as a	consequence	of):											
	Examine	cause. Enter Underlyi (Disease or injury that		С						_								
ed nsit	Exa	events resulting in dea	ath) Last		e to (or as a	consequence	of):											
ficate be executed g physician and sthe burial - transit	<u>ea</u>	UNPENDED		] d	MENDED											_		
3760, ficate be g physicia s the buria	n/Medical	IF FEMALE:												100	1 0 1 - 1	1-11		
	2	23b. Was decedent pre	gnant in the			outcome of preq irth		Feta	l death	3	Ectopic p	pregnanc	v	23	<li>d. Date of o Month</li>		ау	Year
h cerritendii	icia	past 12 months?				ant at time of d			r (Specify									
Box 68 e death certif the attending ed for use as	Physicial	1 Yes 2 No	9 🗹 Unki	nown	9 Unkno	own												
P.O. Box 687 es that the death certific gened by the attending predetached for use as the	by P	Part II. Other significa	ent condition	ons co	ntributing to	death but not	resulting	in the und	derlying ca	use giv	en in Part	1.				_	ne cause of	
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Records, P.O. Box 68. The law requires that the death certicate has been signed by the attendin page 2 should be detached for use as	Completed												24a. Was				ppsy findings mpletion of	
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tal Rection: The lector, page	ပ္	25. Was case referred	to medical						26.	Place of	f Death (C	Check only	-	2		V 163	2	
/ita	Be	examiner?		Hosp	oital: 1	npatient 2	ER/Ou	tpatient		I O	-		lome 5	Reside	ence 6	Other:	Scene	
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ision of Vital I Attending Physician: r death. rector: After this certifi by the funeral director,	S.	1 Natural 5			FOUND		FOU		1	Yes	s 2 🗸 N	<sub>lo</sub> P∈	edestrian	struck	by auto	)		
Signature of the structure of the struct	ical	2 🗹 Accident		igation	Jun 18, 128e, Place	2012 of Injury - Ath	2330 nome, far		factory, of	fice buil	dina. etc.	28	f. Location	(Street a	nd Number	r or Rura	al Route Nur	nber, City
Division of Vital Records, ral or Attending Physician: The law requirers after death.  "I Director: After this certificate has been sited in by the fineral director, page 2 should be the fineral director, page 2 should be the fineral director, page 2 should be the fineral director.	Certification:	3 Suicide 6	deterr	not be nined		Local Stre					•		or Town,	State)			Marbury, I	
Division of a To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral		4 Homicide  29a. Certifier 1 Ce	rtifyina Ph	vsician:		t of my knowled		th occurre	d at the tin	ne, date	and place	_					•	
thin 2 the I	Medical			niner:Or	the basis o	of examination a												
T. w F. io	Š	29b. Signature and title	of certifier		d manner s	Maieu.	_		29c. L	cense r	number			29d.	Date signed	d (Mont	h, Day, Year	)
/ A		1,1,	9 1	1	11	14				C.M.	.E.			Jun	e 19, 20	12		
5 m	ŀ	30. Name and address	of person v	who com	pleted caus	e of death (Iten	n 23a)											
1		Zabiullah Ali, N				al Examine		) W. Ba	ltimore	Street	, Baltim	ore, M	D 21223					
S	ate	31. Date filed (Month, D		1	32. Re	gistrar's Signat												
Regist	TOTAL	JIIN 29	2012	P).	100	11 1	back											1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Emilio L. Nada1 June 2012 3:54 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Hours Director 578-13-2500 1 TX M 2 D F 73 Oct. 9, 1938 Philippines 28a-f show 10a. State 10c. City, Town or Location "natural", or items 23a or 28a-f sho Director 1 Yes 2 No MD Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1905 Reedie Drive 20902 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces þ 1 Never Married 2 Married 2 XNo 72 hours after Yes Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates th Me ical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) CPA Maryland Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ည Felipe N. Nadal Rosario Llanderal Department of Health an Important: If item 27 is r. any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa O. Nadal/Daughter 1905 Reedie Drive, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State San Francisco, Iriga Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State June 22 2012 Iriga City Catholic 4 Donation 5 Other (Specify) City, Philippines 21. Signatura of Funeral Service Lic - ee Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring, MD 20901 23a. Pa.V. Enter the discare, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Hemoptysis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Lung Cancer Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that the death certificate be executed Pneumonia Pneumonia ourial-tran that initiated events resulting in death) Last Due to (or as a consequence of): ng physician as the burial Physician/Medical Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Diabetes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law r page 2 performed' 2 🗌 No Yes 2 X No 1 Tyes of Vital the Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 X No မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide after death Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Deficial Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fi 29a, Certifier Gertifying Nurse Practitioner: To the best of my knowledge death, becamed at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) shaw 0 D60826 June 14, 30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

Registrar

Kshama Garg, MD

1500 Forest Glen Road, Silver Spring, MD 20910

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia	a m /	State of Maryland / Department  1- For State Registrar  Certificate  1. Decedent's Name (First, Middle,Last)	of Death	and	ivicillai	rygierie	Reg. N	20	1	2 209
Medical Exami	anı/ nei					2. Date of Month	Death			3. Time of Death
Sarah Contract of the Contract		David Jeffrey Nowack  4a. Facility Name (if not institution, give street and number)	T 41 01 7			June 2	0, 2012	2		1135 hrs
_		194 Teal Circle	4b. City, Tow Berlin	n, or Lo	cation of Dea	th		4c. County of i Worcester		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		_	lf Under 24H		f Birth(M			place (State or
- Jii dottoi		184 64 9882 1 M 2 F 44  Usual Residence of Decedent	frs. Months	Days	Hours Mi	n. 6/5,	/1968	3	oreign Cou	
, i		10a. State 10b. County 10c. City, Town or Loc	ation							10d Incide O' 11 "
yland -f show	6	MD Worcester Berlin								10d. Inside City Limit  1 Yes 2XX N
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number	10f. Zip Coo	de			10g. C	itizen of What		
ith the	_	194 Teal Circle	2181	1				USA		•
s, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. tem 27 is marked other than "natural", or Items 23a nr 28a-f she traumatic event, the Medical Examiner must be notified at once	Funera	11. Marital Status 1 Never Married 2 Married 2 Married Armed Forces?	Vas Decedent of Yes, specify Cu	Hispan	ic Origin? ( S	pecify Yes or	No-	14. Race - A	merica	an Indian, Black,
ffer de	_	3 Widowed 4 Divorced If Yes, Give Year	Yes 2			o recarr, etc.)		White, e	tc.	
nours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent	ent's Usual Occi	upation (	Give kind of	work done	16h	Specify: Kind of Busine		ite
5-0036 led within 72 he Hygiene. other than "na the Medical Es	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working	life. DO	NOT use ret	ired)	100.	rand of Busine	385/INC	lustry
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21215-0036 Mental Hygiene. Markel Opener than c event, the Medical	8	Clarence Nowack				(First, Middl		Surname)		
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MD and 2 sho alth and 2 is raumati	1	194	Teal Ci	.rc1	e, Ber	lin, M	D 21	811	iale, Z	ib Code)
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr	-	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition crematory or	sition (Name of	cemeter	у,	Date	_	Location - City	or To	wn, State
it. Pag riment ritant:	-	4 Donation 5 Other Specify: Gate of I				5/2012	Dag	gsboro,	DI	Ξ
Baltimore, MD permit. Pages I and 2 sh Department of Health an Important. If item 27 is injury or other trauman			Name and Addre			e Burb	age :	Funeral	. Ho	ome
Physician	1	23a. F. T. Enter the disease, or complications that caused the death. Death and	08 Will	1am					_	
/Medical xaminer	-	Immediate Cause (Final disease a Methadone Intovicati		g,		103piratory a	iii est, snc	ck, or neart		Approximate Interval Between Onset and
Des		or condition resulting in death)  Due to (or as a consequence of):	<u> </u>							Death
		Sequentially list conditions, f any, leading to immediate b. Due to (or as a consequence of):							$\perp$	
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nd ransit	ĬĽ	events resulting in death) Last Due to (or as a consequence of):							1	
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit completed by Physician/Madical	3	☑ UNPENDED ☐ AMENDED 23a,27,28a-f,pc	er me,g	929	7-3-12	sm			+	
760, ficate be g physicist the buri		FEMALE: 23c. If yes, outcome of pregnancy					23d	. Date of delive		
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D. Box 687 I the death certific by the attending probed for use as the	١.	Yes 2 No 9 Unknown g Unknown	ner (Specify)				I			
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Division of Vital Records, rat or Attending Physician: The law requir is after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should briffication: To Be Completed		examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient		of Dea Other	ath (Check or					
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Attend Attend or death. rector: by the f	2	Pending 5 Pendin		Yes 2		nknown		Cocumed		
Division of white of the or and or attending the or atten	3	Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street	, factory, office b	ouilding,	etc. 2	Bf. Location (	Street and	Number or R	ural Ro	oute Number, City
	28	Codifies (Specify) 1 out at a 12 12 12				DELITH	· LIII -			cTe
Division of Vita To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this ca completely filled in by the funeral direct ledical Certification: To Be	on	e) 2 Medical Examiner: On the basis of examination and/or investigation	ed at the time, da on, in my opinion	ate and i	place, and du	e to the caus	e(s) and	manner as star	ted.	-(-)
E STEH	29	b. Signature and title of certifier	29c. Licens					ite signed (Mo		
		his his	O.C.I	M.E.				21, 2012	ini, Di	ay, rear)
	30	Name and address of person who completed cause of death (Item 23a)		_						
State	31	Ling Li, MD Assistant Medical Examiner 900 W. Baltimore  Date filed (Month, Day, Year) 32. Registrar's Signature	Street, Balt	imore,	, MD 2122	3				
Registrar		JUN 2 6 2012 32. Registrar's Signature	Kel							
MH 17 Rev 1/2001		Join to the								

12-04337 Albert B. Pari

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certificate of Death						Reg. No.		2 8 1	
Physicia ledical Exami	an/	1. Decedent's Name (First, Middle ALBERT B	. PARI					2. Date of De Month June 8, 2	eath Day	Year		3. Time of Death 2209 hrs
		4a. Facility Name (if not institution Routes 404 & 313	n, give street and nu	ımber)	4	lb. City, Town, or Denton	Location of	Death		County of aroline	Death	
Funeral Director		5. Social Security Number 573-45-1711	6. Sex 1 M 2 F	7. Age (In yrs. Ia 4.7	ast birthday) Yrs.	If Under 1 Year Months Days		Min.	3irth(MM/C	F	oreign	nplace (State or ntry) CA
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other transmatic event, the Medical Examinet must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 25485 Janice 11. Marital Status 1 Never Married 2 XMa	12. Was Dec Armed Fi 1 Yes Orced of Yes, Give Yes Diffy only highest grace  College (1  Last)  ari  inp (Type, Print)  wife  Removal fractions	Se a  cedent Ever in U.S. orces? 2 X No ar  de completed) 1-4 or 5+)  20b. P	16a. Decedent during mo Super  19b. Mailing 13725  Place of Disposit rematory or other citol (22-Na)	10f. Zip Code 19973 s Decedent of His ss, specify Cuban Yes 2 No 's Usual Occupat st of working life. rintend  Address (Stree 5 Lark tion (Name of cerer place) Cremato	panic Origin , Mexican, F specify: ion (Give kir DO NOT us lent 18.Mother's Ga: t and Numbo La, netery, of Facility	Name (First, Middle yle Emer er or Rural Route No Greenwoo  Date  06/12/20 eral Hon	US  No- 11  State of the state	14. Race - 14. White, a White, a White, a Specify: ind of Busin CONSt Surname)  Surname)  S  y or Town, DE 19. DOVE	Americate.  W state, 2  State, 2  State, 2	an Indian, Black, Thite dustry Ction  Zip Code) 0 own, State DE
Physician {Medical ≟xaminer		23a. Part. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease or condition resulting in death)	complications that co on each line. a. Multiple Inji		Do not enter the			ey St, S diac or respiratory a				Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of)								
760, cate be executed physician and he burial - transit	/Medical Ex	UNPENDED	d AMENDED	· · · · · · · · · · · · · · · · · · ·								
- 15	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unki	e 1 Live b	nant at time of dea	2 Feta	al death 3 [ er <i>(Specify)</i> _	Ectopic p	regnancy		Date of de Month	livery Da	y Year
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ital ician: s certi	Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2 E	EB/Outpotiont		Othor -	heck only one)	Danistan	ce 6 🗸	Othor: C	\
ion of Vital tending Physician: eath. for: After this certi	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi 2 Accident Invest	28a. Date	of Injury	ER/Outpatient 28b. Time of Inj 2209 hrs	jury 28c. Injur	y at Work? es 2 ✔ N	28d, Describe	how injury	y occurred	_	ruck tractor
Division spital or Attendia tours after death.	Certification:	3 Suicide 6 Could	not be 28e. Place	e of Injury - At hor Major Road		, factory, office bu	uilding, etc.	28f. Location or Town, Routes 404	(Street and State) & 313, De	d Number o	or Rura	Route Number, City
To the Hosp within 24 ho To the Func completely f	Medical C	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	ysici at To the bes	of examination and								
H % H 8	¥.	29b. Signature and little of certifier		7		29c. License O.C.N				ate signed 9, 2012		ı, Day,Year)
OCME		30. Name and address of person Mary G. Rippile MD.	who completed caus Deputy Chief M			W. Baltimore	Street, B	Baltimore, MD 2	1223			
St Regist		31. Date filed (Month, Day, Year)	9015   /7	egistrar's Signatur	1. par	del						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month May 31. Benjamin Franklin 8:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth Funeral Months Days Hours (Month, Day, Year) 244-12-8908 **Director** 94 1 X M 2 🗆 F 10/29/1917 North Carolina Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location aţ 10a. State 10d. Inside City Limits Director notified 1 Yes 2X No St. Mary's Hollywood Maryland 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 20636 23588 Three Notch Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ö þ 1 Never Married 2 Married Yes 2 X No er than "natural", c , the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government 10 Electrician traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ Alma Rockwe11 Pike Julia Nathan Addison permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23595 Pike Lane, Hollywood, MD 20636 Robert A. Pike/Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Silas Pike 6/4/2012 4 ☐ Donation 5 ☐ Other (Specify) Pikeville, NC 21. Signature of Funeral Service Licens Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A Ta 41590 Fenwick St., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ omestiv disease or condition resulting in death) Medical Due to (or as a configuence of) Sibuillation. **Examiner** Aturia Sequentially list conditions, n any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Mass. and -trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 2 No the 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown 6 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ terrion 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 Yes မ 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 ☐ Yes 2 ☐ No eral Director: / Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 certificate After this within 24 hours a To the Funeral C

has

Baltimore, Maryland 21215-0036

5) Rme State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakhi Krishnan, M.D. 26840 Point Lookout Road, Leonardtown, Maryland 20650



M.D.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D60888

29d. Date signed (Month, Day, Year)

May 31, 2012

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

Medical

29a. Certifier (Check

29b. Signature and title of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [ ] 2 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Elizabeth Corinne Preston Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Doctors Community Hospital Prince George's Lanham If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) 577-40-6950 **Director** 1 🗌 M 2 🛛 F 83 Yrs, Washington, DC September 23,1928 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🛛 Yes 2 🗌 No Mitchellville Maryland Prince George's 10e. Street and Number 10g. Citizen of What Country? ò r than "natural", or items 23a or the Medical Examiner must be Funeral 10450 Lottsford Road, #1106 20721 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. <u>م</u> 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4 or 5+) Health Industry Scientific Word Processor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Brothers Elsie Dinsmore O'Niell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Henry Preston, Jr. / Husband |10450 Lottsford Road, #1106, Mitchellville MD 20721 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 6/16/2012 Brentwood, Maryland Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 asc 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examin and I-transit NEUMONIA death certificate be executed that initiated events resulting in death) Last ng physician ar as the burial-t Physician/Medical Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ç in the past 12 month 1 Yes 2 No Pregnant at time of death 5 Other (specify) Unknown g 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 1 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral L Medical 29a. Certifier Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 6363 ew. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good L State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)
Jessie Elizabeth Palmer 2. Date of Death 3. Time of Death Physician/ June 10° 2012 12:25PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Prince George's Examiner Prince George's Hospital Cheverly, If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Mantic Pay, Year) 7. Age (In vrs. last birthday) 1914Country) MD **Funeral** Days Hours Min. 1 M 2 SyF 98 Months 578 44 1720 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County within 72 hours after death with the Maryland rral", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits Mitchellville MD Prince George' 1 X Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 11201 Lake Vista Lane 20721 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2**32** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Black "natural", Specify: Completed 3 X Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PVT Homemaker Be permit. Page 1 and 2 should be filed. Department of Health and Mental H-Important: If item 27 is more any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ Katherine Dixon Benjamin Gross, Jr. 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 19a. Informant's Name/Relationship (Type, Print Adrian S. Palmer/ Son Lake Vista Lane Mitchellville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Lincoln Memorial 6/15/12 Suitland, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pridgen Funeral Service, PA 20706 <u>Annapolis</u> Rd. Lanham, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1  $\square$  Live Birth 2  $\square$  Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year Pregnant at time of death signed by the a 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate 1 Yes 2 No 2 X No Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Inpatient 2 ER/Outpatient 3 DOA မြ 1 Yes within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directions. 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Date of Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No iniury 5 Pending 2 Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

ag

Centur

vho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

7925 Greenwa

VETZMA

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 20942 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Reginald James 2012<sup>Yea</sup> Pearman, Sr. June 11 2320 hrs. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign 116-22-6641 Director 89 1 X M 2 🗆 F May 23, 1923 New York 28a-f show at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 X Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Numb ō 10g Citizen of What Country? ms 23a or must be Funeral 9118 September Lane 20901 United States death 12. Was Decedent Ever in U.S.
Armed Forces? U.S. Army
1 X Yes 2 Dec. 1945
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Black "natural", 3 Widowed 4 X Divorced Year or Dates. Feb. 1947 Completed r than "ne. "he Medical F Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working U.S. Department Elementary/Secondary (0-12) College (1-4 or 5+) 5+ years Grant Analyst of Education marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F ೭ William H. Pearman traumatic Astoria Arabel Webb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 and 2 s t of Health a If item 27 i 9118 September Lane; Silver Spring, Maryland 20901 Lydia Pearman Harris (Daughter) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ō 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Maryland Cheltenham Veterans Cemetery Maryland Sonature of Puneral Service 22. Name and Address of Facility R. N. Horton Company Morticians, andelph MU1421 Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final **Physician** Respiratory Arrest disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Emaciation Sequentially list conditions, rany, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to rui da a curraculience uir that the death certificate be executed Sepsis and that initiated events Due to (or as a consequence of): resulting in death) Last physiciar Physician/Medical Dehydration Box 68760 the as attending IF FEMALE: ase 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ō Day Year Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy death? certificate Yes 2 X No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other 2 X No 1 Yes 은 1 X Inpatient 2 DER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pendina death. Accident Suicide Investigation To the Funeral Director: / 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined after City or Town, State) To the Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 06-2011

State

(Check

29b. Signature and title of certifier

Nooshin Farr,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

M.D.; Holy Cross Hospital; 1500 Forest Glen Road; Silver Spring, Maryland

D32247

29d. Date signed (Month, Day, Year)

June 12, 2012

20910

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death June 10. 2012 5:05 A M Physician/ Pietruska F. Jean Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Solomons Asbury-Solomons Health Care If Under 24 Hrs Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 12/14/1916 95 England 577-40-0677 1 □ M 2 🏲 F Director Usual Residence of Deceder 10d. Inside City Limits 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director Solomons 1 Yes 2xxNo Maryland Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number England Funeral 20688 11750 Asbury Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2xXNo Specify: White "natural", Completed 3 Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry permit. Page 1 and 2 should be filed within 72 !
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event the proce. life DO NOT use retired) Elementary/Secondary (0-12) British Embassy Clerical Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Taylor Alice Agnes Harding Peter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8351 Shorecrest Drive, Ft. Myers, Florida 19a. Informant's Name/Relationship (*Type, Print*) **Howard Stern / Attorney** 33912 20b. Place of Disposition (Name of cemetery, crematory or other place)
Md. Vet. Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 Cremation 3 Removal from State 06/18/2012 Cheltenham, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 Signatur Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ un disease or condition Medical resulting in death) Due to (or as a consequence Examiner Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed ohysician and the burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ☐ Live Birth 2 ☐ retai uea ☐ Pregnant at time of death in the past 12 months? Month Dav 5 Other (specify) Yes 2x X No ate has been signed by the a page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

eral Director: After thi certificate has filled in by the funeral frector, page 2. autopsy performed? 1 Yes 2 No Yes 2 x No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4xxNursing Home 5 ☐ Residence 6 ☐ Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide within 24 hours a Medical 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

Registrar

DHMH 17 Rev 06-2011

State

29b. Signature and title

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John J. Barth

JUN 1 4 2012

29c. License number

110 Hospital Drive Prince Frederick, Maryland

00

522

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ рМ CATHERINE LILLIAN 2012 JUNE 20 6:56 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Elkton Cecil Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 M 2 F Days Auq 17 1925 86 Delaware **Director** 222-14-7424 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Cecil Earleville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1459 Glebe Rd. 21919 U.S.A. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 X No Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Clothing Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jerry Husfelt Florence Groves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Franklin Poore, Sr. (husband) 1459 Glebe Rd. Earleville, MD. 21919 20b. Place of Disposition (Name of cemetery, crematory or other place)
Zion Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Department of h
Important: If ite
any injury or oti 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 6/26/12 Cecilton, MD. Denation 5 Sther (Specify nature of un Servi Calena Funeral Home of Stephen L. M00510 118 West Cross St. Galena, MD. the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, eart failure. List only one cause in each line. Ente Approximate Interval Between Onset nd De th shock or Immediate Cause (Final disease or condition Physician/ Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 as IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? sate has been signed by the atte page 2 should be detached for Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. **Other\_significant condition\$** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case ref re to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 2 🚺 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 KER/Outpatient 3 DCA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHNK 31. Date filed (Month, Day, Year,

DHMH 17 Rev 7/2009

Registrar

W. Main

104

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2012 James Wesley Randall, Sr. 5:00 A M June Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 02/27/1921 Forestville, MD Months Hours 91 577-18-2599 **Director** Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f shov or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Charles Hughesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6937 Crockett Court 20637 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, rmed Forces?

Yes 2 \quad No Black White etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 🕅 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Shop Foreman Fire Department Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles R. Randall Elsie Pyles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James W. Randall, Jr. / Son 6937 Crockett Court, Hughesville, MD 20637 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 06/12/2012 Clinton, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 ₩M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on part line. Approximate Interval Between Conset and beath Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Lary, leading to initial additional cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 2 🗌 No ed by the a 1 ☐ Yes 2 ☐ Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been siy completed filled in by the funeral director, page 2 should to completed filled in by the funeral director, page 2 should to complete the funeral director. 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy perform death? YERRAR 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who

R1 Date filed (Mont)

9449

Charlotte Hal

cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		4	For State Registrar	State of Ma	ryiand / Depa Cer	tificate of L			Reg. No.	2012	20948
		Ļ	Decedent's Name (First, Middle, L.	ast)				2. Date of De	ath	Voor	3. Time of Death
	Physicia Medic	al .	Carol A. Robins					Month 06	10	2012	11:30 A <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, gi				r Location of Death			unty of Death	
			16 Cedar Circle 5. Social Security Number 6.		(In yrs. last birthday)	North I		8. Date of Bir		ecil	lace (State or Foreign
H	Funeral Director		216-44-1908 Usual Residence of Decedent	1 M 2 🛛 F	68 Yrs.	Months Days	Hours Min.	(Month, Da 11/25)	1943	Count	
	ind show at	. h	10a. State 10b. County		10c. City, Town or Loc	cation				1	Od. Inside City Limits
	/anyla 8a-f s tified	rect	MD Ce	il	North	East					1 ☐ Yes 2 🔀 No
	the N		10e. Street and Number			10f. Zip Code			10g. Citizen	of What Coun	try?
	s 23a	Funeral Director	16 Cedar Circle	e			1901			USA	
	death ritem nern		11. Marital Status	12. Was Decedent Ex Armed Forces?	er in U.S. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - America Black, White, e	
Baltimore, Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other tranmatic event, the Medical Examiner must be notified at	ed by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 1 1 N If Yes, Give Year or Dates.	1	☐ Yes 2X No	Specify:		Spe	ecify: W	hite
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an	should be file n and Mental I 7 is marked o raumatic eve	욘	Benjamin Robin	son			Ruth Mi	ller			
ary	hould and M is ma		19a. Informant's Name/Relationship		19b. Mailin	g Address (Street	and Number or Run	al Route Numbe	er, City or Tou	vn, State, Zip C	ode)
Σ	and 2 s Health tem 27		011ie Gill - g	randson			Drive, Pe	rryvi11			
ore	Page 1 and 2: ment of Health ant: If item 27 ury or other tr		20a. Method of Disposition 1 ☐ Burial 2 🎛 Cremation 3	☐ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other plac		Date 7/2012	20c. Locat	ion - City or To	wn, State
ij	it. Pag rtmen rtant: njury		4 Donation 5 Other (Spe	**	R.T.Foard		Home, PA			g Sun,	
Ba	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funeral Service Lion	Property Open	lie   22		ess of Facility R. t Main St				
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	Medical Examiner		resulting in death)	Due to (or as a	consequence of):	0					
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687	eath certific attending p	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d	I. Date of delive	erv
Box 68760	eath o atten I for u	Physician/M	in the past 12 months?	4 Pregnant at	2 Fetal death 3 L time of death 5 C	Ectopic pregnan   Other (specify) _	су				Day Year
О. В	the d by the	hys	g 🗌 Unknown	9 Unknown							
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Ĕ	ician: The certificate rector, pag		25. Was case referred to medical	1		26. P	Place of Death (Chec		2 No	1 🗆 Yes	2 L No
Vita	lysicia is cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Outpatier	Oth			dence 6 🗆	Other (Specify	
Division of Vital Records,	<b>Jing Physician:</b> The la h. After this certificate ha funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injur (Month, Day,		wor	ḱ?	28d. Describe	how injury oc	curred	
sion	or Attending after death. Director: After in by the funer	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	t be 28e Place of Injur	ry - At home, farm, str		Yes 2□No	28f Location (	Street and No	umber or Rural	Route Number,
Σ.	al or A s after I Direction by		4 Homicide determin	building, etc.		,,,		City or To	vn, State)		
_	To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Medical	(Check 2 Medical Ex	hysician: To the best of raminer: On the basis of ex	camination and/or inves	tigation, in my opini	ion, death occurred a	at the time, date	and place, an	d due to the car	use(s) and manner stated.
	To the within 2 To the Comple	ž	only one) 3 Certifying N 29b. Signature and title of certifier	urse Practioner: To the b	pest of my knowledge,	death occurred at the		ce, and due to th		id manner as st igned (Month, I	
	1			ers MD						./2.20	
	艾		30. Name and address of person wh	no completed cause of de	eath (Item 23a) (Type, F	Print)	193322 Eleton	$m_0 \supset m$	22/		
	Sta	te	31. Date filed (Month, Day, Year)	32, Pegistra	r's Signature	my 10 31	C-10.01	219	74.	<u> </u>	
	Registr	ar	JUN 1 2	2012	4 1	250					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 0F/08/5075,ear Physician/ 8:29 Theodore Junior Riddick Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Cheverly Prince Georges Hospital Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min. 238-72-7611 Director 1 **X** M 2 □ F 02/21/1947 NC 65 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 No MD Prince Georges Brentwood 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? r items 23a or ner must be n ò Funeral AZU 20722 3719 40th Pl. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1911 1661 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and 2 should be filed within 7. Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+ Maintenance Eingineer General Maintenance event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Martha Purvis Alphonso Riddick injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat 4865 Young Rd., Waldorf, MD 20601 Theodore Riddick, Jr. / son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Dopation 5 Other Specific Heritage Memorial Cem: 06/18/2012 Waldorf, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signat <u>6500 Allentown Rd., Camp Springs, MD 20748</u> 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): nding physician a use as the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 performed this certificate Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes မ ER/Outpatient 3 DOA ✓ Inpatient 2 □ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident filled in by the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npletely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) COL 29b. Signature and title of pertifie 29c. License number 304

State Registrar Name and address of person who completed cause of death (Item 23a) (Type

32. Registrar

Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 16, 2012 8:00 A M Henry Ruby Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8601 Temple Hill Road #43 Temple Hills Prince George's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Director 579 46 0608 1**XX**M 2  $\square$  F Washington DC Oct 31, 1936 Usual Residence of Decede 28a-f show 10c. City, Town or Location 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 🗆 Yes 2 📉 No Temple Hills MD Prince George's 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20748 8601 Temple Hill Road #43 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 XXMarried à 1 Yes 2 XX No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) the Railroad Engineer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental has is marked of Delena Burkehead Charles Phipps Ruby other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a : If item 27 is 8601 Temple Hill Road #43, Temple Hills, MD 20748 Diane Ruby (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State ō Department of Important: If any injury or June 19, 2012 | Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria 21. Sign ure of Funeral Service Lice mo1555 Ferry Road, Clinton, MD 20735 23a. har 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cancer Colon disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury for use as the burial-trai that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 4 | Pregnant : 9 | Unknown been signed by the a should be detached Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 N Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🕱 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ျ 2 **XX**No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

7525 Greenway Ct Dr Greenbelt, MD 20770 State

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Weltz, M.D.

D23743

June 18, 2012

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND PI LINE C-D, PER MD G930 8/30 12 TRT
For State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2.9 2012 15:14 p RAYMOND ROBINSON Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthday) Social Security Number If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Davs Hours Min 2-21Day, Ye Director 227-72-7068 60 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2x No Prince Georges District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20747 USA 1904 Altamont Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 Widowed 4 Divorced Completed Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Navy 12th Bus Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ည Janice Deloris Benton Raymond McCoy Robinson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) District Heights, Md 20747 Janice A. Robinson-Wife 1904 Altamont Pl. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cem 6-9-2012 Suitland, MD 21. Signature of Funeral Service Licenses Marshall-March Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ OVO disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed CEREBRPVASCULAR ACCIDENT that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical DIABETES Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year 5 Other (specify) Month Day Pregnant at time of death signed by the a Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗹 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 has certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital 1 🗌 Yes 2 1 No ျှ 2 ER/Outpatient 3 DOA 1 Inpatient within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 244 06 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave. Takoma Park, MD Shahab 32. Registrar's Signature State Registrar

Baz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 17:08 06-07-2012 Marvin Russell Simmons Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Peninsula regional Medical Center Salisbury Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs, 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days Hours (Month, Day, Year) 236-48-2950 Director 1 X M 2 □ F 06-13-1933 West Virginia Usual Residence of Decedent permit. Pege 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23e or 28a-f show eny injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 X No Maryland | Wicomico Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21849 8927 Pittsville Rd. 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give USAF Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8 Maintenance -Welder Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Orpha Lynn Propst Oscar Bowman Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Jane Simmons | wife 8927 Pittsville Rd., Parsonsburg, MD 21849 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 06-12-2012 4 Donation 5 Other (Specify) Pittsville Cemetery Pittsville, Maryland of Funeral Service Licensee HÖlloway füneral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 Dom 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Pregnant at time of death 4 Pregnant 1 Yes 2 No this certificate has been signed by the rail director, page 2 should be detached Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death?
 □ Yes 2 □ No 24a. Was an autopsy performe Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 NER/Outpatient 3 IDOA 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d, Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

Records, Division of Vital

> TOTIVA A

State Registrar

Medical

29a. Certifier (Check only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ihris Snyder D.D.

JUN

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

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32. Registra s Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Murse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

21301

NO

11/2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2012 8:00 a.m June THOMAS SAN ANTONIO Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Mary's 23140 Cobblestone Lane, Apt. 109 California 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number Funeral Days Min Hours 064-18-0182 Director 1 **X** M 2 □ F 89 New York Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County #0c. City, Town or Location 10a. State event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland St. Mary's California 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number ō items 23a Funeral 20619 United States 23140 Cobblestone Lane, Apt. 109 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give 1943-45
Year or Dates. Black, White, etc ò þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry l Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Medical Audiologist should be filed with and Mental Hygien is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev Maffia Jant Padrouaggio Guiseppe San Antonio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23140 Cobblestone Lane, California, Maryland 20619 Betty San Antonio-Spouse Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06/08/2012 Cheltenham, Maryland Cheltenham Veterans 21. Signa on or of era Service Lenser

Edward N. Brinsfield Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD Mooo52 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not, inter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conse un nce of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a conscionation of Examir Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? or Attending Physician: The law requires that the death Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown cate has been signated; Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe death? 1 Yes 2 No hours after death. uneral Director: After this certificate Yes 25. Was case referred to medica 26. Place of Death (Check only one) funeral director, Be examiner? 101 Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 5 Pending Investigation filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a To the Funeral L Hospital Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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State

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Registrar

29b. Signature and title of certifie

30. Name and address of p

Jennifer 31. Date filed (Month. D.O.

Schmidt,

JUN 0

on who completed cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

40900 Merchants Lane, Suite 205, Leonardtown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 2012<sup>Year</sup> 3:45 AM Charlene Farrall Sparrow Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Prince Frederick Calvert Hospice House 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 06/21/1942 Xear) 1 M 2 X F 220-40-3644 Mary Land Director 69 Usual Residence of Decedent show 10b. County 10c City Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State **Funeral Director** 1 Yes 2 X No Maryland Calvert. Prince Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20678 660 Willow Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Was Decedent Ever in U.S. Was Deceue... \_ Armed Forces? 1 ☐ Yes 2 🙀 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Administrative Assistant Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ဂ္ Cecelia Elizabeth Goldsmith Ferdinand Charles Farrall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 660 Willow Way Prince Frederick, Maryland 20678 Susan Cecelia Higgs / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John Vianney Cemetery 06/19/2012 Prince Frederick, MD 22. Name and Address of Facility Rausch Funeral Home, PA. 21. Signature of Funeral Service Licenses 4405 Broomes Island Road, Port Republic, Maryland 20676 Kyle S. Simons MO1200 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC LUNG CANCER Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Z4 hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit elect filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 No Yes 1 🗌 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 2 No 4 Nursing Home 5 Residence 6 W Other (Specify) Hospice House ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 only one) 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 2 KW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 110 Hospital Road, Suite 310 Prince Frederick, Maryland 20678 Peter Wisniewski, MD 31. Date filed (Month, Day, Year) 32. Registrar Signat State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SINCLAIR **Physician** 5:40 PM 2012 4 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL GRACE 1) E HARTORD MEMORIAL HAVRE MARFORD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/14/1957 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1₩ 2□ F 212-70-5049 54 Pennsylvania **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla D. partment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantmer must be notified at any injury or other traumatic event, the Medical Evantmer must be notified any once. 1 ¥Yes 2 □ No Directo Perryville Maryland Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Owen Court 21903 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo If Yes, Give XY Year or Dates: Specify: White Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Insurance Agent</u> Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Edgar Sinclair Doris Wilks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cynthia Sinclair (wife) 32 Owen Court, Perryville, Maryland 21903 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition West CHester, 1 ☐ Burial 2X Cremation 3 ☐ Removal from State RA Ferris & Co. 06/15/2012 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Furn Zellman Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD 23a. Part 1. Enter the discrete, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 XNO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Tyes 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Bank D0058913 JUNE Mari Era 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 SOUTH UNION BAHL MANISHA MD MD HAVRE DE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

LG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Marie Frances Smith 2012 8:40 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours Min (Month, Day, Year) 214-18-3402 Director 1 M 2 XF 95 3/3/1917 MD 28a-f shov 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits the Maryland must be notified at **Funeral Director** MD Baltimore Nottingham 1 Yes 2 No 10f. Zip Code 5 10e. Street and Number 10g. Citizen of What Country? 23a with 4128 Kahlston Road 21236 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ral", or iten Examiner r 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Elizabeth Cook Joseph Valentine Kahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 4212 Valley Vista Ct., Manchester, MD 21102 Roger M. Smith, son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ★ Burial 2 Cremation 3 Removal from State 6/1/2012 Department of Important: If any injury or Joppa, MD Mountain Christian Cem 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home M00741 934 S. Main St., Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Due to (or as a consequence of) Examine if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Was deceu...
in the past 12 month

✓ Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Į, Month Year Day Pregnant at time of death be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 N has page 2 certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? CR Other: မ 1 🗌 Yes 2**X** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 2 🗌 No Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifie artifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Neocal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) Mil

Stat

Registrar
DHMH 17 Rev 06-2011

Name and address of person

401

who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

32

Baltimore,

Box 68760

P.O.

Records,

**Division of Vital** 

Registrar DHMH 17 Rev 06-2011 mpleted cause

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAJUAN STRIGGLES JUNE 10 OSiOZAM Medical 2012 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Manyland Medical Center University 6. Sex Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 578-66-9984 Director 1 🗆 M 2 🔀 F 61 Dec. 25, 1950 DC Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits the Maryland Director must be notified 1 🔀 Yes 2 🗌 No Lanham Maryland Prince George's 10g. Citizen of What Country? ö 10e. Street and Number 10f. Zip Code Funeral 23a 20706 7308 Powhatan Street United States items death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. o þ 1 Never Married 2 X Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: **Black** Completed 3 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. I **other than** ' life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Cosmetologist Self-Employed event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ Thelma Spriggs traumatic Joseph Andrew Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trauonce. 414-Milfan Drive Capitol Heights, Maryland Thelma S Battle - Mother 20743 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June I9, cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 2012 Washington, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Buston M01605 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** current mos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transi? Cause (Disease or injury that initiated events resulting in death) Last 5 m 0) ntraabdomina Due to (or as a consequence of): ending physician a Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Day Year Pregnant at time of death been signed by the s should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? After this certificate 2 1100 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completely filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weld 440 Grindall St. Baltimore

31. Date filed (Month, Day, Year) 32. Registrar's Signature

5 2012

29c. License numbe

D0071039

21230

29d. Date signed (Month, Day, Year)

10,2012

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	State of Mar	-			Mental Hyg	giene	0 00057		
			Registrar  1. Decedent's Name (First, Middle, Last)	Cei	rtificate of D	eatn	2. Date of Dea	Reg. No.	3. Time of Death		
	Physicia	n/	Bernice Louise Ste	11 oh			Month June	Day 201	r		
	Medic Examin		4a. Facility Name (if not institution, give street and number)	TTOIL	4b. City, Town, or	Location of Death	June	4c. County of De			
	Examili		11450 Asbury Circle, Unit 306		Solomons	3		Calvert			
	Funeral		1 DM 2 DE	n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 11/21/1	9. E	Birthplace (State or Foreign Country) SSOURI		
	Director		498-20-1997   Superior   Electric   Superior   Superior	34 Yrs.			111/21/1	927 M18	ssouri		
	and show			0c. City, Town or Lo	ocation				10d. Inside City Limits		
	Maryk 28a-f stified	Director	Maryland Calvert	Solomons					1 ☐ Yes 2 🖼 No		
	a or 2 be no		10e. Street and Number		10f. Zip Code			10g. Citizen of What United S			
	th with ms 23 must	Funeral	11450 Asbury Circle, Unit 30		20688 Was Decedent of Hi	enanic Origin? (Sp	ecify Yes or No-		merican Indian,		
	r dear	굣	11. Marital Status  1 □ Never Married 2 ☑ Married  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ Narried		If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Wi			
200	rs afte	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🙀 No	Specify:		Specify: W	nite		
<del>ر</del> د	2 hou "natu adical	blet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d	ation Juring most of work	king	16b, Kind of Busines	ss Industry		
121	ithin 7 ene. • than he Ma	Sol	Elementary/Seconday (0-12) College (1-4 or 5+)		oo NOT use retired) istered Nu	ırse		Health	Department		
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or unatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)		1000100		ne (First, Middle,	Maiden Surname)			
/Jan	d be f Aenta arked rtic ev	욘	John William Brunkhorst			Elise E	lisabet	h Lohmann			
lan	shoul and t is ma		19a. Informant's Name/Relationship (Type, Print)	- 1				r, City or Town, State,			
و ف	1 and 2 should be filed wit if Health and Mental Hygie item 27 is marked other other traumatic event, the		Reynold Frederick Stelloh, Jr./Spot 20a. Method of Disposition	1SE 1145 20b. Place of Disp		circie,	Date JUNIE	20c. Location - City	s, MD 20688		
Baltimore,			1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, cre	matory or other place an Cremator		8/2012	Alexandria,			
뵱	permit. Page Department ( Important: If any injury or once.		21. Signartife of Funeral Service Licensee		2. Name and Addres			neral Home			
ñ	Imp Dep any		Enichael Kleven Hardine	h					, MD 20657		
			23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line.	he death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory an	rest,	Approximate Interval Between Onset and Death		
	hysician/		Immediate Cause (Final disease or condition a. 422/	TIMETO	25 00	PHONT	TA		Onset and Death		
	Medical Examiner	ı	resulting in death)  Due to (or as a continuous)	consequence of):							
		Je.		consequence of):							
	od d ansi	Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events  C								
	ate be executed bhysician and the burial-transii	al Ex	resulting in death) Last Due to (or as a	consequence of):							
9	cate be physic the bi	edical	d								
P.O. Box 687	ath certifica attending p	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of	pregnancy				23d. Date of	delivery		
30X	leath of atter	sicia	in the past 12 months?  1  Yes 2 No		☐ Ectopic pregnand ☐ Other (specify)			Month	Day Year		
o.	requires that the de been signed by the should be detached	Phys	9 Unknown  Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause di	ven in Part I	23e Did t	obacco use contribut	e to the cause of death?		
σ.	es tha signed	d by	CVA	The resulting in the	andonying onder g			/	☐ Probably 4 ☐ Unknown		
Sign	been should	lete					24a. Was		autopsy findings available		
ecc	rsician: The law s certificate has b lirector, page 2 s	dmo					auto perfo 1 🗆 Yes	ormed? death	to completion of cause of h? Yes 2 🏻 No		
a F	ian: Ti rtifical rtor, pa	Be C	25. Was case referred to medical examiner?		26. P	ace of Death (Che					
₹	hysic his ce il direc	2	1 ☐ Yes 2 ☑ No 1 ☐ Inpatier	nt 2 ER/Outpati		4 L Nursing F		dence 6 Other (S	pecify)		
οι	ling P.	ate	27. Mann of Death 28a. Date of injury (Month, Day,		work		28d. Describe	how injury occurred			
Division of Vital Records,	Attend r deatl ctor.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injur	y - At home, farm, s				Street and Number or	Rural Route Number,		
ΟĬ	s afte		Sullding, etc.				City or Tov				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check (	mination and/or inve	estigation in my opini	on death occurred	at the time, date a	and place, and due to t	the cause(s) and manner stated, I		
	To the within To the somple	Σ	29b. Signature and title of dertifier	and or high strictmine of	29c, Licens		and the total	29d. Date signed (Me			
		-	The state of the s		D674	95		June 18,	2012		
1	0. IE		30. Name and address of person who completed cause of de			0.44 0100	C-1	- MD 2000			
d	RW 15	10	Kenneth S. Villar, MD 140	s Signature	ueman Road,	оште 2100	, Solomons	s, PD 20000			
	Sta Regista		31. Date filed (Month, Day, Year) 32. Registra	news B.	parker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month / 16/2012 4:55 am Merton Ignatius Stone **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Calvert Dunkirk 10997 Two Sisters Lane Birthplace (State or Foreign Country) 8. Date of Birth (Month Day, Year) 06/07/1921 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1**₺** M 2□ F 231-12-9315 91 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10b. County 1 ☐ Yes 2 🛣 No or items 23a or 28a-f show the Michael Examiner must be notified at Dunkirk Calvert Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20754 U.S.A. 10997 Two Sisters Lane Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 21215-0036 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Navv n and Mental Hygiene. Machinist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Baltimore, Maryland Be Ruby May Woodburn Pages 1 and 2 should be nent of Health and Mental William Thompson Stone 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10997 Two Sisters Lane, Dunkirk, MD 20754 permit. Pages 1 and 2:
Department of Health a
Important: If item 27 Is
any Injury or other trau Denise Scherl/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 06/20/2012 Cedar Hill Cemetery 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Juneral Service Licensee 8200 Jennifer Lane, Owings, MD 20736 Isa M. Mounts Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical as the 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy use 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Year 3 Ectopic pregnancy Month for in the past 12 months? 5 Other (specify) 2 No ned by the a 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 21 No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No 1 Yes certificate 26. Place of Death (Check only one 25. Was case referred to medical Be examiner' Other: Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 1 Yes No Certification: To 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760, After this

Hospital or Attending Physician: Director: filled in by the 24 hours a within 2 To the

27. Manner of Death

Natural

2 Accident

3 ☐ Suicide 4 Homicide

29a. Certifier

cal

5 Pending investigation

6 ☐ Could not be determined

JRW State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 033123 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jonathan Lowenthal, M.D. 110 Hospital Road, Suite 310, Prince Frederick, MD 20678

1 ☐Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

32. Registrar's Signature 31. Date filed (Month, Dey, 2012 Clenus

28a. Date of Injury (Month, Day, Year)

Registrar

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	State of Maryland 1- State Amend#26 perphysTT 6/1	/ Depa 9 / Cei	artment of I	lealth a	nd Me	ental Hyd	T 6/20	142	20	959
	Dhusisi		1. Decedent's Name (First, Middle, Last)				1	2. Date of Dea Month	Day	Yeer	3. Time of I	
E STATE OF THE PARTY OF THE PAR	Physicia /Medic		David Glenn Sampson			June				15 II	5:00	Ам
577	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o		f Death		4c. County o	Aru:	ndo1	
			Crofton Convalescent Center  5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthdav)	If Under 1 Year	fton If Under 2	24 Hrs.	B. Date of Birtl	n	9. Birtho	lace (State or	r Foreign
0.	Funeral Director		214-14-3365 1⊠ M 2□ F 91	Yrs.	Months Days		Min	(Month, Da) March	r, Year)	Coun	land	
			Usuel Residence of Decedent									
	how	_		Town or Lo	cation					11	0d. Inside Cit 1 X Yes	
	Ba-f a	Director	That year of the state of the s	wie					40-011			
	with th	E E	10e. Street and Number		10f. Zip Code	716			10g. Citizen of W US		try r	
	s 23	Funeral	4205 Enterprise Road  11. Marital Status  12. Was Decedent Ever in U.S.	13 1			gin? (Spec	ifv Yes or No-			an Indian,	
10	iter d	Fun	Armed Forces?  1 □ Never Married 2 □ Married 1 ▼ Yes 2 □ No		Was Decedent of I If Yes, specify Cub		, Puèrto R	lican, etc.)		c, White,		
99	al', or	þ	3 ⊠ Widowed 4 □ Divorced If Yes, Give WWII		1 ☐ Yes 2 🖾 No	Specify:			Specify:	Wh	ite	
2-0	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show rdical Exam ar must be multiked at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occur kind of work done	during most	t of workin	g	16b. Kind of Bu	siness/Ind	dustry	
Maryland 21215-0036	C . 01	mpi	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retire hinist	ed)			Harry D	iamo	nd Lab	s
12	Hygir Ther		12 17. Father's Name (First, Middle, Last)	Tiac	HIHISC	18. Mothe	r's Name	(First. Middle.	Maiden Sumame	e)		
and	0 to 0	Be c	Hugh Bueford					le Rip				
<u>Z</u>	d 2 should be f th and Mental H 7 is marked of traumatic eve	스	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street	1				State, Zip	Code)	
	- E N =		David Glenn Sampson, Jr. / Son	2977	7 Vincent	t Circ	le, N	1echani	csville.	, MD	20659	
re,	ーエック		20a. Method of Disposition 20b. Pla	ce of Dispo	sition (Name of matory or other pla	ace)	Da		20c. Location -	City or To	wn, State	
E					oln Ceme		6/22	/2012	Brentwo	od, l	Maryla	nd
Baltimore,	permit. Pag Department Important: I any injury o once.		21. Signature of Funeral Service Licensee		2. Name and Address Fu		•	, P.A.	4739 Ba Hyattsv			
	55 F		23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory ar	rest,		Approximate Interval Bety Onset and D	ween
	Physician		Immediate Cause (Final disease or condition	heus	+ laill	MR					Oriset and L	70401
	/Medical Examiner		resulting in death)  Due to (or all a conseque	ince of):	100							
	Examine:	_	Sequentially list conditions, if any leading to immediate b. Due to (or as a conseque	TECH &	my DI	Man						
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68	ntifical ng ph as th	ledi	IE EENALE.									
Вох	th cer tendir or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnand 1 Live birth 2 Fetal deceded to the pregnand of	death 3□	∃Ectopic pregnanc	су			23d. Date Mor	e of delive		rear
	at the dea by the at tached fo	sici	1   Yes 2   No 9   Unknown	ıth 5□	Other (specify) _							
P.0	that the		Part II. Other significant conditions contributing to death but not result	ting in the u	nderlying cause or	ven in Part I.		23e. Did to	obacco use contr	ibute to th	ne cause of d	eath?
Records,	signed be det	Completed by	change Penal insuffice		, , , ,			101	res 2□No	3 Prob	ably 4 🖒	Inknown
200	w require been sig should b	ete	D + M					24a. Was	an 24b. V	Vere auto	psy findings a	available
Rec	The lav	dmi	Pie- NEWAL More mila					autor perfo	rmed?	rior to co leath?	mpletion of ca	ause of
_	certificate	e Co	25. Was case referred to medical			26 Place	of Death	1 ☐ Yes (Check only o		∐ Yes	2□ No	
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of	9 Physical control		27. Manner of Death 28a. Date of Injury 2	28b. Time o	f 28c. Inju				now injury occurr			
io	ath. r: After ne funer	atio	2 Accident investigation	,σ.,		]Yes 2□	No					
Division	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)		reet, factory, office	•	2	8f. Location (S City or Tox	Street and Numbern, State)	er or Rura	al Route Num	ber,
Q	oital c urs aff rat Di						1					
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 1 ☑ Certifying Physician: To the best of my know (Check only 2 ☐ Medical Examiner: On the basis of examination and manner stated.	ledge, deat on and/or in	h occurred at the to vestigation, in my	time, date an opinion, dea	nd place, a ath occurre	nd due to the d at the time,	cause(s) and ma date and place, a	nner as s and due to	tated. the cause(s	.)
	ro the	Me	29b. Signature and title of certifier		29c. Licen	ise number			29d. Date signed			
	1	D 0062395 6/18/12										
	144)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2772 Rutland Road										
	•		ALFONSO A GOMA	n	MP	David	lwonv	ille, N	① 21035			
9.	Sta Registi		31. Date filed (Nonth, Day, Year) 32. Registrar's Signatu	الما								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **JAMES** ARTHUR SOLOMON Day 12:30 P M JUNE Medical 2012 **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5308 Chesterfield Drive Temple Hills Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ Days 09/26/1948 **Director** <u> 256–76–7757</u> 63 Georgia Usual Residence of Decedent 28a-f shov 10a. State 10b, County at 10c. City, Town or Location 10d. Inside City Limits Director notified MD Prince George's Temple Hills 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code ıral", or items 23a oı Examiner must be 10g. Citizen of What Country? Funeral 5308 Chesterfield Drive 20748 USA 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 □ NoVIETNAM If Yes, Give Year or Dates. —**ERA** 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) the Laborer Government 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ of Health and Menta fitem 27 is marked r other traumatic ev James Solomon Ruby Landford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annie Mack/Sister 5308 Chesterfield Drive Temple Hills, MD 20748 Department of Heal Important: If item 3 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maryland Veterans 06/21/2012 Cheltenham, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home HUS 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CARDIOPULMONARY ARREST disease or condition resulting in death) Examine attending physician for use as the burial

Physician Medical **Examiner** 

certificate be

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death

Page 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

cate has been signed by 1 page 2 should be detach

the

Physician/Medical ģ Completed Be မ Certificate: within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

Medica

29a. Certifie (Check

only one 29b. Signature and title of certification

31. Date filed (Month, Day,

الله الله

Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra 's Signature

Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	CHRONIC OBSTRUCTIVE PULMONARY DI  Due to (or as a consequence of):  ATHEROSCLEROTIC CORONARY ARTERY  Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnancy  1		23d. Date of delivery Month Day Year
Part II. Other significant conditions con	tributing to death but not resulting in the underlying cause given in Part I.		b use contribute to the cause of death?  2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of
OF Was seen referred to market		performed?	death?
25. Was case referred to medical examiner?	26. Place of Death (Che		
1 X Yes 2 ☐ No	ospital: 1	Home 5X Residence	6 ☐ Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)  28b. Time of injury 28c. Injury at work?  M 1 \[ \text{Yes} \ 2 \end{D} \] No	28d. Describe how inju	
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Physic	ian: To the best of my knowledge, death occured at the time, date and place,	and due to the cause(s)	and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

JUNE 13, 2012

29c. License number

#ME 91750

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DHMH 17 Rev 7/2009

Registrar

ROBERT MARK KAISER, M.D., VAMC,50 IRVING STREET NW, WASHINGTON,DC 20422/688

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 7am James Francis Swann June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Plata **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 215-46-1988 Director 1 XM 2 D F Yrs 07-13-1945 66 Washington D.C. or 28a-f shov 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Charles La Plata 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 10780 La Plata Road 20646 United States Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Completed by Black, White, etc. 1 Never Married 2 Married Yes If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 🗌 Widowed 4 🗆 Divorced Specify: Year or Dates Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas Robert Swann Mary Grace Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .03 Important: If item 27 is any injury or other trau Annie T. Swann/Sister 10780 La Plata Road, La Plata, Maryland 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 06-22-2012 Sacred Heart Cem. La Plata, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Arehart-Echols Funeral Home, M00945 St. Mary's Ave. La Plata, Maryland 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Coronary disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical certificate be the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy ρ in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar certificate has autopsy perform Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient R/Outpatient 3 DOA After this funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 8b. Time of 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending Natural Accident 5 Pending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu work? 1 ☐ Yes 2 ☐ No Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, and in account a time date and place, and due to the cause(s) and in amort as stated. (Check 29b. Signature and title of certifier 29c. License number 2017 **ፖ**ላላላ የ*ያል*ላንላን 6 on who completed cause of death (Item 23a) (Type, Print) State Registrar

29b. Signature and title of certifier

K. Mathur 31. Date filed (Month 703

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MALLITAM THOMAS SMITH JUNE 20<sup>Day</sup> 2012<sup>Year</sup> 11:58 ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Worcester Berlin Atlantic General Hospital . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Oct 25 1946 **Director** 215-44-6930 1 XM 2 □ F 65 Maryland Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Director notified 1x Yes 2 □ No MD Ocean City Worcester 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral 707 St. Louis Ave. 21842 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, item 27 is marked other than "natural", or itel other traumatic event, the Medical Examiner Armed Forces?

Mar Yes 2 No 1966 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. -1968 Completed 3 Widowed 4 Divorced 5. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Carpenter Self-employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ပ J. Earl Smith Lola Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traunonce. Pearl S. Plummer (sister) 23192 Old Fairlee Rd. Chestertown, MD. 21620 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Kent Cremation Services 6/22/12 1 Burial 2 X Cremation 3 Removal from State Smyrna, DE. 4 Donation 5 Other (Specify) Galena Funeral Home of Stephen L. Schaech 118 West Cross St. Galena, MD. 21635 M00510 of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. shock, or nterval Betweer Immediate cause (Final disease condition resulting in death) Onset and Death ESDIVATOR Phylician/ Medical as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DOB iolas/194 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Tes ည 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Calling Sures exactlitioner: To the original of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Calling Sures exactlitioner: To the original of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 29c. License number 20 D0066198 person who completed cause of death (Item 23a) (Type, Print) Justinian Ngaiza, M.D. 314 Franklin Ave. Suite 108, Berlin, MD. 21811 32. Registar's Signature 31. Date filed (Month, Da State 29 Registrar

*B* 

10D

06 20/2013

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $2^{\frac{rear}{0}}2$ 10:20 PM 30 Jill Denise Thomas 05 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1199 Long Valley Road Carrol1 Westminster Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Months Hours Min. **Director** 175-48-3191 1 □ M 2 🗶 F 48 02/01/1964 PA Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1

Yes 2 □ No Carroll MD Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21158 USA 1199 Long Valley Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2X Married ş Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Public School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Shirley Shively Harvey Boyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 Ronald Thomas/husband 1199 Long Valley Road, Westminster, MD altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 06/04/2012 | Hampstead, MD Greenmount Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address Pfritts Funeral Home and Chapel, PA de Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Paset and Death Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of) use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 1 Ectopic pregnancy Month Dav Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 1 Yes 2 No 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 esidence 6 Other (Specify) Certificate: To I 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 06/01/12 ause of death (Item 23a) (Type, Print) Charles St. Towson M) 21204 address of perso onegu 20 31. Date filed (Month egistrar's Signature

State

Registrar

JUN 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>D</sup>2012 Physician/ June 21:45 10 Lillie Mae Toye Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bradford Oaks Nursing Home Clinton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) **Director** 426-36-2354 1 □ M 2 🛛 F Yrs. 1920 Oct. 11, Mississippi Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 Yes 2 No Fort Washington <u>Mar</u>yland Prince George's 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code "natural", or items 23a or edical Examiner must be Funeral 8504 Bella Vista Terrace 20744 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married **Black** Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🖾 No Specify. If Yes, Give Year or Dates 3 X Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 1 and 2 should be filed within 72 of Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Registered Nurse Government traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Emma Liddell Pleas Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 or other tra 9802 Green Apple Turn Upper Marlboro, Md. Richard A Toye - Grandson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 16. permit. Page 1 a
Department of H
Important: If ite
any injury or oth cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 2012 Landover, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stewart Funeral Home, Inc. John Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Pancreatic Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, indirections to the cause. Enter Underlying Examine Directly for as a consequence off law requires that the death certificate be executed sician and e burial-trans Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death ed by the a detached 1 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ 1 Yes 2 No 3 Probably 4 Unknown been signated beautiful be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has the director, page 2 s performed? Yes 2 X No 1 Yes 2 No Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 **X**No Other: 4 Marsing Home 5 Residence 6 Other (Specify မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27 Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Certificate: (Month, Day, Year) 1 X Natural 5 Pending death. leral Director: At filled in by the fu 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined after 24 hours 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Pragtition er: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 29b. Signature and title of certifie well

Registrar DHMH 17 Rev 06-2011 William T. Tanner, MD 11701 Livingston Rd. #101 Fort Washington, MD 20744

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

D35206

June 15, 2012

		AMI	Please END #25, PER MD G93	Type or Print in BI	ack Indelible Inl	k. Ensure All	Copies A	e Legible	•
			_ State	State of Maryland	Department of F  Certificate of E			201	2 20066
			Registrar  1. Decedent's Name (First, Middle, Last	5)	Certificate of L		Reg. No. 2. Date of Death	Vo. CU 1	3. Time of Death
ı	Physicia Medic		MARY	Elizabeth	Thomas		Month [	Day Year	09 27 AM
-	Examir		4a. Facility Name (if not institution, give	street and number)	4b. City, Town, or	Location of Death	1	c. County of Dea	
71-18	fi.		Prince George	Hospital	Che	verly		Prince	George
	Funeral		5. Social Security Number 6. Se	.,,	birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	<ol> <li>Date of Birth (Month, Day, Year)</li> </ol>		rthplace State or Foreign ountry)
	Director		218 - 16 - 0687 1 [ Usual Residence of Decedent	□ M 2 🕱 F 90	Yrs.		9-16-2	21 MA	Ryland
	shov d at	tor	10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	Mary 28a-1 otifie	irec	Manyland Prince	George H	ynthsulle				1 ☐ Yes 2 ☐ No
	death with the Maryland r items 23a or 28a-f show iner must be notified at	Funeral Director	10e. Street and Number 3201 75th	1	10f. Zip Code		10g. (	Citizen of What Co	ountry?
		nuel	3201 75 <sup>+h</sup>	12. Was Decedent Ever in U.S.	13. Was Decedent of Hi	0725 ispanic Origin? (Speci	fv Yes or No-	14. Race - Ame	vicen Indian
(O	s after dea al", or ite Examiner	by F	1 Never Married 2 Married	Armed Forces?	If Yes, specify Cuba	ın, Mexican, Puerto Ri	can, etc.)	Black, Whit	
21215-0036		ed	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates.	1 🗌 Yes 2 🏋 No	Specify:		Specify:	3lack
5-0	72 hou "natu ledica	plet	15. Decedent's Ed (Specify only highest grad		6a. Decedent's Usual Occup-		16b.	Kind of Business	/Industry
12	thin 7; ene. than he Me	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	ife. DO NOT use retired)	Aler		Dame	atro.
	s filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	Be	17. Father's Name (First, Middle, Last)		110	18. Mother's Name (	First, Middle, Maide	n Surname)	3 170
Maryland	should be file n and Mental H is marked o raumatic eve	입	Frank	Stewart	-	Carrie	E.	WA	atson
ar)	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Ty)	oe, Print)	19b. Mailing Address (Street a	and Number or Rural F	Route Number, City	or Town, State, Zi	p Code)
	1 and 2 s if Health item 27 other tr		Marry Washingto		1 - 1 11111	St. Capit		<del></del>	20743
Baltimore,	0	1	20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □	Removal from State cem	e of Disposition (Name of etery, crematory or other plac			Location - City or	Town, State
ΙŧΪ	permit. Page Department Important: I any injury or		4 Donation 5 Other (Specify  21. Signature of Funeral Service License	7.*	Lincoln Cei		2-12   51	uitland	141)
Ba	permi Depar Impor any ir		21. Signature of Funeral Service License	W. Vuene	22. Name and Address	ss of Facility	P. A	144500	MD 20608
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that calls d the death. D		g, such as cardiac or r	- / / / / /	44300	Approximate
	Physician/		Immediate Cause (Final	e cause on each life.	india. Or	abutha	0.1.0		Interval Between Onset and Death
€	Medical		disease or condition resulting in death)	a. Due to (or as a consequent	ce of):	<u>o gragilor</u>	ma		muces
100	Examiner	L.	Sequentially list conditions	b					
	si q	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce of):				
	e executed vian and urial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	ce of):				
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68760	ficate g phy as the	/ledi		u					
9	endin r use	an/I	Zob. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal de		ev.		23d. Date of de	livery
Box	death	Completed by Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of deat 9 Unknown		,		Month	Day Year
P.O.	at the d by t detach	Phy	Part II. Other significant conditions co	ntributing to death but not resulting	ng in the underlying cause giv	ven in Part I.	23e Did tobacco	use contribute to	the cause of death?
	res th signe d be c	d by	h	1 Kerlension	•		i _		Probably 412 Unknown
Records,	requi been shoul	lete	, A	Clarent Clare	0.440		24a. Was an		itopsy findings available
ec	ne law e has age 2	dwo		write an	er di ini		autopsy performed	prior to death?	completion of cause of
E B	an: Th tificat tor, pa	Be C	25. Was case referred to medical	wine won	e desecon	ace of Death (Check o	1 Yes 2	No 1 Ye	s 20 No
of Vital	nysici lis cer I direc	일	examiner? 1  Yes 2 No	lospital:	Outpatient 3 DOA Othe	er: 4  Nursing Home	e 5 🗆 Residence	6 ☐ Other (Spec	cify)
of	ng Pł fter th uneral		27. Manner of Death  1   Natural 5 □ Pending	28a. Date of injury (Month, Day, Year) 28	b. Time of 28c. Injury work		d. Describe how inj	ury occurred	
ion	tendi death. tor: A the fu	ific	2 Accident Investigation 3 Suicide 6 Could not be			Yes 2 No			
Division	or At after Direc I in by	Certificate:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, factory, office	28	f, Location (Street a City or Town, Sta		iral Route Number,
	spital	ical	29a. Certifier 1 Certifying Physi	ician: To the best of my knowledg	ge, death occurred at the time	e, date and place, and	due to the cause(s)	and manner as s	tated.
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical		er: On the basis of examination and Practition of Tolly basis of the b					
	Voith voith com		29b. Signature and title of certifier	M	29c. License	number		ate signed (Mont	h, Day, Year)
	6		Jann 11.	Oliver, W	1) 11	7579	V 0	ne 15	2012
	ba		30. Name and address of person who co	ompleted gause of death (Item 23	(,)	earre 1	DRIVEY.	Chent	ely UD
	Sa	•	31. Date filed (Month, Day, Year)	3 Registrar's Signature	ho. del	J	1	VICT	
	Pagietr			IS I MUSICAL DI.	Late Late				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Curtis Ulery 7:38 A. M 2012 June 8, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert Prince Frederick Burnett-Calvert Hospice House 8. Date of Birth (Month, Day, If Under 1 Social Security Numbe 7. Age (In yrs. last birthday If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 170-42-6841 59 Oct. 29,1952 Pennsylvania Director 1 XM 2 F Usual Residence of Decedent show or 28a-f shov notified at 10b. County 10c. City, Town or Location death with the Maryland Director Huntingtown Calvert MD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a or ner must be r Funeral 40 Sun Park Lane United States 20639 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Examiner Armed Forces? 1

✓ Yes 2 No Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 is marked other than "natural", or ō þ 1 Never Married 2 Married 1 Yes 2 □ No If Yes, Give 1973–1976 Year or Date 1973–1976 Maryland 21215-0036 Specify: White 1 Yes 2 XNo Specify: 3 Divorced 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Federal Aviation Elementary/Secondary (0-12) College (1-4 or 5+) Air Traffic Controller Administration 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arnold Dale Ulery Mary G. McMillan Rudd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 40 Sun Park Lane, Huntingtown, MD 20639 Pauline Ulery/Wife other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 8 Department of H Important: If ite any injury or otl Page 1; George town University 1 Burial 2 Cremation 3 Removal from State Washington, D.C. 4 Donation 5 Other (Specify) 2012 Medical Center nature of Funeral Service Licensee 22. Name and Address of Facility Columbia Mortuary Services, P.A. /M00969 9013 Annapolis Road, Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between ta Immediate Cause (Final Onset and Death Physician/ rears disease or condition \_Medical resulting in death) Examiner Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? tos pice Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital r Attending work? 1 ☐ Yes 2 ☐ No 1 🔀 Natural injury 5 Pending Accident Acciden
Suicide Investigation Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Zemedical examiner: on the basis or examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causets) 3 Li Certifying Nurse Practitioner: To the best of my knowledge, death occurred the time, date and place, and due to the cause(s) and manner as stated. 1005906 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) dRW 2 ne Frederick MD HOSPITO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1, per phy, g929 7-2-12 sm State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Abdurrahman Vural 2. Date of Death Physician/ Month Day Vear 3:40 P Abdurrahma Medical June 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospita Frederick Frederick 6 Sex If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months **Director** 224-49-5790 1**X** M 2 □ F 46 Jan 9, 1966 Turkey Usual Residence of Deceden 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 ☐ Yes 2X No MD Silver Spring Montgomery ō 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 8210 Grove St. 20910 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. þ 'natural", or 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XNo Specify. Completed 3 Widowed 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Cosmetologist Cosmetology is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Dondu Macit Osman Vural 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Cheryl Vural/former wife Westminster, MD 14 Bond St. 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadow Branch Cemetery 6/25/12 Westminster, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facili Pritts Funeral Home & Chapel, PA 21157 412 Washington Rd. Westminster, MD Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ -010 rec tal Canle disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) the burial-trans and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Dav be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 🗌 No 1 Tyes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital à No Other: ပ္ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural To the Hospital or Attending work? 5 Pending injury 2 No Accident Suicide Investigation after death Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one

State

Registrar DHMH 17 Rev 06-2011 29b. Signatu

e and title of certifier

Hemenshah

31. Date filed (Month, Day, Year)

MI

cThomas

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tohorson

6-23-2012

Frederick MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Agnes Cecelia Wheeler 2012 2:50 P M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 37575 Manor Road St. Mary's Chaptico If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 218-80-7250 Director 76 Yrs 12/03/1935 Maryland Usual Residence of Decedent should be filed within 72 hours are warm and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show it marked other than "hatural", or items 2ba or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland St. Mary's Chaptico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 24313 Hurry Road 20621 12, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 White 1 ☐ Yes 2 🙀 No Specify 3 X Widowed 4 Divorced Specify: Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Harry Knott, Sr. Alice Elizabeth Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Deborah Kay Hall/ Daughter 24365 Hurry Road Chaptico, Maryland Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 06/09/2012 Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A
41590 Fenwick Street Leonardtown, MD 20650 Signature of Funeral Service Licase 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Promotion/ CONGESTIVE WEEKS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** ATRIAL YEAR! Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 DIABKTKS MKLLITUS 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy death? 2 XNo Yes 24 hours after death.

Funeral Director: After this certificately filled in by the funeral director, Daughter's 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🔀No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Residence 1 Inpatient 2 ER/Outpatient 3 DCA မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred il or Attending F after death. Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town. State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2 To the I

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bauer, M.D. 28103 Three Notch Rd., Mechanicsville, MD 20659 Robert J.

5 aver

(Check

29b. Signature and title of certifier

Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0014168

29d. Date signed (Month, Day, Year)

6-7-12

			Plea	ase Type o										_	ible.		
		For State		State	of Mary	/land /					and N	Mental Hy	/gien	e	2 1 6		007
	-	Registrar  1. Decedent's Name	e (First. Middle	e. Last)			Cer	rtificat	e or L	<i>Jeatn</i>		2. Date of D	Reg. N	lo.	4	1 2 Time	e of Death
Physicia Medic												Month June	D	ay <b>4</b>	Year 2012		15 A M
Examin		4a. Facility Name (if						4b. City,	Town, or	Location	of Death		4	c. County	of Death		
		39090 Ho		ive 6. Sex	T7 Ago (In	urs last hi	rthdayl	If Unde		anics If Under		e 8. Date of Bi	uth	St.	Mary		to or Foreign
Funeral Director		227-36-16		6. Sex 7. Age (In yrs. last birthday 79 Yrs.			-	Months		Hours	Min.	(Month, D	ay, Year)	′ ′′			
ow 1		Usual Residence o			1.10	c. City, Tov		antine.				04/27/	1933			rgini	a City Limits
aryland a-f sh fied a	Director	MD		Mary's		Mecha			P						:		Yes 2X No
or 28		10e. Street and Nur	L	nary B		1100110		10f. Zip					10g. C	Citizen of V	Vhat Cou		
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death r item iner n		11. Marital Status	T	12. Was Dec Armed F	orces?	in U.S.	13. \	Was Deced If Yes, spec	lent of His	spanic Ori n, Mexicai	gin? (Spen, Puerto	cify Yes or No Rican, etc.)	-		e - Ameri k, White,	can Indian, etc.	ı
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To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	(Check 2	🗌 Medical E	Physician: To the Examiner: On the ba Nurse Practitions	asis of exam	ination and	or invest	tigation, in	my opinio	n, death o	ccurred at	the time, date	and place	e, and due	e to the ca	ause(s) and	manner stated
To the within To the compl	Σ	only one) 3 29b. Signature and		nurse Fractitione	er: to the be	St Of HIJ KIT		290	. License	number			29d. D	ate signed	(Monty),	Day, Year)	
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DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2012 Year Physician/ June Lillian Anna Walker 12 6:00 Αм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Chesapeake Shores Nursing Center Lexington Park St. Mary's Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 04725/1929 New Jersey 83 **Director** 157-26-5245 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location ould be filed within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or items 23a or 28a-f shormatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗆 Yes 2 🙀 No Prince Frederick Maryland 1 4 1 Calvert 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1323 Grove Court 20678 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc ò 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ t. Page 1 and 2 should be intreent of Health and Mentartant: If item 27 is marked njury or other traumatic e John Hatman Mattie Landon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Allen / Grandaughter 23580 FDR Blvd., Unit #401, California, Maryland 20619 Department of Health Important: If item 27 any injury or other to Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitian Crematory 06/15/2012 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, PA Kyle S. Simons MO1206 4405 Broomes Island Road, Port Republic, Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events equence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 4 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has all director, page 2 s autopsy performed Yes 2 2 🗌 No 1 Yes funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? s after death. I Director; After t 28d, Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after To the Funeral Dire Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completed Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 2012

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KW

Registrar

Name and address of person who

e filed (Month, Day, Year) JUN 15 2012

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death ent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harwood Examiner 4c. County of Death Mandrin House Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Nov 25 1938 Director 165-32-2565 1 🔀 M 2 🗆 F 73 Pennsylvania Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It has 23a or 28a-f show then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Port Republic Maryland Calvert 1 Yes 2 No 10e. Street and Number 10f. Zip Code Og. Citizen of What Country? United States Funeral 3835 Broomes Island Road 20676 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 58If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 Never Married 2 1 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) contruction truss designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna Mae Kilheffer ဂ Joseph Wertz, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Walker - spouse 3835 Broomes Island Rd. Port Republic Maryland 20676 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o cemetery, crematory or other place)
Metropolitan Funeral Service June 15 2012 Alexandria Virginia 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home PA o Kausa 4405 Broomes Island Road Port Republic Maryland 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deathy Immediate Cause (Final disease or condition Physician/ eliom min Medical resulting in death) Examiner tos Sequentially list conditions, if any, hading to immediate cause. Enter Underlying Examine anding physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ģ in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 2 No sate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death. Funeral Director: After this certificate by 2 ZN 1 Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\bowtie$  Other (Specify) Hospital: 2 210 မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifier 29c. License number 7)16 of personwho completed cause of death (Item 23a) (Type, Print Name and address LRW

State

Registrar

. Date filed (Month, Day,

s Signature

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14-2012 John Franklin Wilson 3:29 AM C 9-Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury Hospice at Wicomico -oastal the Lake If Under 1 Year If Under 24 Hrs. . Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 A F Months 63 Days Hours Min. (Month, Day, Year) 31-66-9091 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Princess Anne 1 Yes 2X No MD Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21853 USA 14042 Allen Rd Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced Completed white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maintenance Maintenance Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gerald Hampton Wilson Betty Lee Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14042 Allen Rd., Princess Anne, MD 21853 Betty J. Wilson / mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Makemie Churchyard 6/18/12 Snow Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) f Fun Service Licensee 21. Signatur 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ MALIGNANT LUNG CARCINDUM disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine cause. (Disease or linjury Directorior as a nonsequence of and that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year signed by the a detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 2 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes ₽ □ N within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Other (Specify) 1 🗌 Yes HOSPI GE ဂ္ 1 Inpatient 2 Impatient 2 Impatient 3 Impa 27. Manner of Leath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work' 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the of certifier 00058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 2+1 130

DHMH 17 Rev 7/2009

State Registrar CelfluAu 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 2012 12:20 P<sup>M</sup> Brian M. Washington June 10, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Fairmount Heights 5526 K Street 6. Sex If Under 1 Year If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Year) Director 1 X M 2 | F 579-96-3587 46 Sept. DC show 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 28a-f 1 X Yes 2 No Reedville Virginia Northumberland 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 22539 351 Harris Grove Lane United States 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc by 1 ▼ Never Married 2 ☐ Married X Yes Yes, Give 2 No 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Private Paralegal 12th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Lola E. Cogdell Roosevelt Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of Item 27 i 96029 Roxabogue Dr. Fernadina Beach, FL 32034 Cecelia W. Chambers - Sister or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lee's Crematory  $\bar{2012}$ Clinton, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Stewart Funeral Home, Inc. M00560 20019 4001 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Metastatic Lung Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last this certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Live Signature of death 3 Ectopic pregnancy
5 Other (specify) **Hospital or Attending Physician:** The law requires that the death of thours after death. in the past 12 months? Dav Year Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Yes To the Hospital or Attending Physician: T within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 XNo ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify) Friend 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) jocetyne 163748 June 18, 2012

State

Registrar

DHMH 17 Rev 06-2011

Calverton, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jocelyne Kouatchou 4041 Powder Mill Road Suite 600

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2012 Year Dorothy Ellen Yingling June 5 12:36 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Homewood at Crumland Farms Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 26 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 Year. Director 218-40-0730 77 1935 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location at 10d. Inside City Limits death with the Maryland Director MD 28a-f Frederick Frederick 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral 23a 7407 Willow Road 21702 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. ò Completed by 1 Never Married 2 Married 1 Yes 1 Yes 2 No Specify: D.O.D. Jime 5, 2012 3 X Widowed 4 □ Divorced Specify: White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) presser clothing factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Leonard Horner Dessie Grimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Pittinger - daughter 119 Challedon Dr. Walkersville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Dak Hill Cem. 5/8/2012 4 ☐ Donation 5 ☐ Other (Specify) LeGore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw F.H. Baltimore St. Taneytown, 136 Ε. MD 21787 23a. Part). Enter the disease, or complications that caused the death, o not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) hingling Medical s a consequence of: **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, Exami burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Known to Physicians as: Dorothy Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perfor Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowled -, death - cured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investig (Check ion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, deat occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature se of death (Item 23a) (Type, Print) ress of person who completed c FREDERICK MARYLAND 21701 KAUFMANN

State

an

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

HUAL Q 6

12-04806 John Abbott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici	an/	Registrar  1. Decedent's Name (First, Middle,L	.ast)		timour					12	2. Date of De	Reg. No. eath			3. Time of Death	1
	ıl Exami		John Wheeler	Abbott								Month June 26,	Day 2012	Year		1605 hrs	
			4a. Facility Name (if not institution, g					-	wn, or Lo	cation of I	Death			. County of			
			Atlantic General Hospita					Berlin		1011 1 1	2.41.1	lo p		Vorceste		1 (0)	
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	the Maryland a or 28a-f show tifted at once.	Director	10e. Street and Number			cear		Of. Zip C	ode				10g. Citi	izen of Wha	at Count		-
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:	with the same as 23a ce not		11. Marital Status	12. Was Decedent	Ever in U	.S. 1	3. Was [			nic Origin	? ( Spe	cify Yes or N			Americ	an Indian, Black	
	r item	Funeral	1 Never Married 2 Marrie	ed Armed Forces?	No		If Yes,	specify (	Cuban, N	/lexican, P	uerto R	ican, etc.)		White,			
,	after death with the Maryland  al", or items 23a or 28a-f sh  iner must be notified at once	by F	3 Widowed 4 Divorc	ed If Yes, Give Year 1	966-	69	1 🗌 Y	es 2X	No .	specify:		_		Specify: V	hit	:e	
	SE 클립		15. Decedent's Education (Specify							n (Give kin O NOT us			16b. I	Kind of Bus	iness/in	dustry	
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215		Be (	Ralph W. Abbo	ott						Lill	iar	v.	Jarı	cell			
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ē,	20 44 E S I		20a. Method of Disposition  1 Burial 2 X Cremation	3 Removal from Sta		Place of C	or other	place)		•		Date		Location - (	•	,	
Baltimore,	Pages ment of tant: If or other	10	4 Donation 5 Other Speci		At	Tant										nie MI	
Bal	permit. Page Department o Important: injury or oth		21. Signature of Funeral Service Lic	ensee		- 1	22. Nan	ne and Ad	adress of	SH	Has Sel	ting byvi	s Fi	nera DE1	il I 1975	Iome	
Ph	ysician		23a. Part. Enter the disease, or cor		the death	. Do not e										Approximate In	
10	dedical.	8 19	failure. List only one cause on Immediate Cause (Final disease	each line. a Multiple Injuries											13	Between Onse Death	at and
±Χ	aminer		or condition resulting in death)	Due to (or as a conse	equence o	rf):											
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Box 68760	death certificate be e attending physici for use as the buri	/We	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of preg	nancy	7			le			23	d. Date of c			
689	ending use as	Physician/Me	past 12 months?	1 Live birth 4 Pregnant at	time of de	2 Leath 5	Fetal	death · (Specify	3 <u></u>	Ectopic pr	regnan	СУ		Month	Da	y Yea	ı
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<u>12</u>	ysician: his certif director,	BB	25. Was case referred to medical examiner?	Hospital: 1 Inpatie	m. 2 . d	ER/Outp			I Ot	Death (Cl		ly one) Home 5	Deside	ence 6	Other:		
<b>&gt;</b>	ling Physic After this funeral dir	욘	1 Yes 2 No 27. Manner of Death	I III III III III		28b. Tim				at Work?		8d. Describ			<u> </u>		_
Division of Vital Records,		ë	1 Natural 5 Pending		ear)	1545 h	rs	·   1	I  Yes	2 🗸 N	。  P	river in a	n auto	to auto	ollisio	n	
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	To the within To the comple	Medical	29b. Signature and title of certifier	and manner stated.	апона	. Idroi IIIVe	Janyanon		icense r		ou at	unie, uai				h, Day, Year)	
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_ \	X gr		30. Name and address of person wh	o completed cause of d	eath (Item	23a)											
1	1.0		Pamela E. Southall, MD	Assistant Medi		,	900 V	V. Balti	more s	Street, E	Baltim	ore, MD	21223				
	St Regist		31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	Je Jav	4										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ O G 8:00 am 2017 Medical Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1050 E. 33rd Street N/A Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 219-42-8490 **Director** 1 XM 2 - F 66 11/18/1945 N.J. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City. Town or Location Director 1 XYes 2 No N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1050 E. 33rd Street 21218 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 Married by Yes, Gi Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify. Completed 3 Wildowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) Self Employeed 12th yrs. Mortgage Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ollie George Armstrong Laura Mae Conway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kimberly Armstrong-Daughter 3724 Ravenwood Ave. Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State On Site Cremation 7/3/2012 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H-U 1101 E. North Ave. Baltimore, MD21202 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a Part shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition tema Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atte in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 3 Probably 4 Unknown 1 Yes 2 L Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
1 Yes 2 No 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 1-Secrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5017 ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 711 W SMCC 40 State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2012 June 7:19 A M Arredondo Laura Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Director 217-65-2021 1 M 2 X F 84 Aug 25, 1927 Peru show 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring MD Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral 20902 Peru 11226 Watermill Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Force þ 1 X Never Married 2 Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify: Specify: Native American "natural", Completed 3 Widowed 4 Divorced Peruvian Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home Be ild be filed v Mental Hyg 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ျ Arredondo-Mogrovejo Justina Zegarra-Ccoscco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health s 11226 Watermill Ln. Silver Spring, MD 20902 Edith \_Rondon / Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Woodbine, Maryland Journey Crematory 7/4/2012 21. Signature of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 MO1651 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical Box 68760 the phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes 2 X No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 X No မ 1 Inpatient 2 I ER/Outpatient 3 X DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After t 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month. Day, Year) D43539 June 29, 2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Raymond White

31. Date filed (Month, Day, Year)

1500 Forest Glen Rd.

32. Registrar's Signatur

Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2012 ALTEN BURY 4:15 Рм KOLAND June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford House of Jubilee Fallston Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 □ F Months Days Hours July 08, 1920 91 Baltinore, MD 214-18-2224 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director notified 1 Yes 2 X No Harford Street Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be Funeral 23a Page 1 and 2 should be filed within 72 hours after death with 21154 U.S.A 1309 Quaker Church Road items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 🖾 Yes 2 🗆 No 1942—
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc. , 0 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) Telecomunications Milling Machinist AT& T Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Barbara Ann Fugel Herman Leroy Alterburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1309 Quaker Church Road, Street, Maryland 21154 Mr. Tracy Cadden (Grandbaughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Funeral Chape 1 Durial 2 X Cremation 3 Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Pel Air Jeffrey R. Ter (M01543) 22. Name and Address of Chapel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 Signat Testemen R 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or year failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Dementa star YC2-5 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Yarkinsm's Year, Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): sician Physician/Medical Division of Vital Records, P.O. Box 68760 phys the l attending p as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Chronic GREMIA 24a. Was an certificate has b lirector, page 2 s autopsy performed 450V10 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 🗌 Nursing Home 5 🗆 Residence 6 🗹 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 Natural 5 ☐ Pending \_\_Investigation s after de. ral Director: A Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours after
To the Funeral Directory Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6/29/12 1) 3/295 XI

State Registrar

Kenwood

Ave

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

Klaesz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Alice Bangert Month 10:17PM 2012 June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Center Towson Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Hours (Month, Day, Year) 235-36-3312 Director 1 □ M 2 🔽 F 87 Yrs. May 5, 1925 West Virginia 28a-f show 10b. County 27 is marked other then "naturel", or items 23a or 28a-f sho treumetic event, the Medical Exp. items at the routiled at 10c. City. Town or Location 10d. Inside City Limits Director Baltimore Co. Baltimore MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera United States 21224 201 Old North Point Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married \$ 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed 3 Divorced Specify White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 l th and Mental Hygiene. 7 is marked other then "r College (1-4 or 5+) Elementary/Secondary (0-12) Own Home 12 Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Tencie Boggs Otis Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Old North Pt. Road Baltimore, MD 21224 1 and 2 s of Health item 27 i Mr. George J. Bangert(Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If it
any injury or or
once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 7/3/2012 Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Ave. Dundalk. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami The lew requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): resulting in death) Last ete has been signed by the attending physician pege 2 should be detached for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 2 110 ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) ca 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29c. License number 68W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death \_\_\_\_\_2<u>012</u> Physician/ Month June 14, Deborah Ann Bentley 7:30 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 27 Shropshire Court Reisterstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Min Hours Director 172-48-9368 1 🗆 M 2 🗓 F 55 Sept 11, 1956 Pennsylvania show 10a. State 10c, City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Reisterstown 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 27 Shropshire Court 21136 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Force Black, White, etc. 2 No 1 Never Married 2 Married Yes 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: If Yes, Give white 3 Widowed 4 X Divorced Year or Dates. unk 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than '
injury or other traumatic event, the Me life, DO NOT use retired) Elementary/Secondary (0-12) 12 service industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOhn Bernard Carroll Deborah Ann Siegel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Prospect Blvd #A3 Frederick, MD Karen Sealover/sister 21701 Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 🔀 Donation 5 🗌 Other (Specify) Rona I u 28 Name and Address of Easility Board 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Cancel disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events Due to (or as a consequence of): Examin signed by the attending physician and deed be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical requires that the death certificate be **)EBOLYH** *BENTLE*ヤ Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery in the past 12 month 1 Yes 2 No 3 Ectopic pregnancy Day 5 Other (specify) Pregnant at time of death 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been sit completely filled in by the funeral director, page 2 should I Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗶 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury Natural 5 Pendina 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 🕉 💢 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29c. License number

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R130272

DULAGLEY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Evelyn E. Becker 2012 4:47 AMM <u>June</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday Funeral 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) 1 □ M 2 🛛 F Director 212-09-4764 97 Jan 9, 1915 Maryland sual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🖵 No Baltimore Parkville 5 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 8830 Walther Blvd #331 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Black, White, etc. 6 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "naturai", Specify: white 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene, item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4 or 5+) pharmacy technician healthcare æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lawrence Frazee Minnie Wetzler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Adele Alvather/niece 12536 Merritt Avenue Fork, injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If its any injury or ot once. Page 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) e di Funeral Servici ROMATO Licensee S.W State Anatomy Board 655 W. Baltimore Street Director MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SEPSIS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami sate has been signed by the attending physician and page 2 should be detached for use as the burlal-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death, that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 autopsy performed Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 💢 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the Hosp within 24 hou To the Funer completely fi 29a. Certifier (Check only one) 3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month

Registrar

DHMH 17 Rev 06-2011

State

4:47

EVELYN BECKER

2300 DULANEY VALLEY RD.

TIMONIUM, MD 2109B

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

MORGAN

0 3 2012

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Boyd ack 1:58 PM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death of Maryland Medical Center University Baltimore, MD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 214-72-8185 Director 1 🔀 M 2 🗆 F 53 08/01/1958 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1X Yes 2 ☐ No 0 10e. Street and Number 10f. Zip Code ral", or items 23a or Examiner must be 10g. Citizen of What Country? Funeral 5110 Baltimore Nal't Pike 409 21229 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. er than "natural", or the Medical Examin by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Manekin LLC Security Guard <u>12th grade</u> permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jack Boyd Ada Bell Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacquetta Boyd/Daughter 3120 Windsor Ave.Baltimore MD.21216 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 06/06/12 Arbutus, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Mem.Park <sup>22. Name and Address of Facility</sup>Chatman-Harris Funeral Home 5240 Reisterstown RD.Baltimore MD.21215 21. Signatur / Funeral Service Licenses HOES 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physi i n disease or condition resulting in death) qua movs Medical Due to ( as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Oncertying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and I-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 ed by the attending p detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Pregnant at time of death Day Year Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 sl performed 1 🗌 Yes 2 🗆 No Yes 2 No burs after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year, 5 Pending injury work' М 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and

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State Registrar Green Street Baltimore, ma 2120)

who completed cause of death (Item 23a) (Type, Print)

22 South

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :20 AM Jun 3012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Lpcation of Death 4c. County of Death 64 Mayland Melizal dimore 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Director 219-42-3837 1 X M 2 □ F 67 Oct. 26, 1944 Washington, DC ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 Yes XX No MD Queen Annes Stevensville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral "natural", or items 23a 205 Somerset Road 21666 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. by 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Lisual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 I and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12th Disabled α Disabled Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ William Lawrence Bowles Lillian M. Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh
Department of Health an
Important: If item 27 is
any injury or other trau Philip M. Bowles/Son Stevensville, MD 205 Somerset Road, 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Cther (Specify) Fort Lincoln Cem. 7/3/2012 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line.

Immediate cause (Final disease or condition resulting in death) M01103 313 Talbott Avenue, Laurel, Approximate Interval Between Inset and Death Physician/ Omin Medical as a conse fience of): Examiner hours Esquentiary list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury emosthagic that initiated events resulting in death) Last attending physician for use as the buris Tibia Fracture Physician/Medical Comminuted that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Live Birth 2 L Fetai deal 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA P 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Jun 27, 2012 Unknown M 1 Yes 2 No Investigation Could not be 119 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide 205 Somersel 1) Stevensville, MD 21666 Home within 24 hours a To the Funeral D Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29d. Date signed (Month, Day, Year) 6621 2012 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of J. S. Greene Baltimor 21 20 Date filed (Month, Day, 's Signature State

HMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution give street and number or Location of Death Examiner Inton If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In Irs. last birthday) If Under 1 Year 6. Sex **Funeral** Months Min (Month, Day, Year) Country Washingter **Director** 1 🗶 M 2 🗆 F 01.15. 10d. Inside City Limits or 28a-f shov 10c. City, Town or Location 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State the Maryland Director 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? arlboro Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 □ No If Yes, Give and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 56 1 Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced -57 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working of Health and Mental Hygiene.
item 27 is marked other than other traumatic event, the Me DO NOT use retired Elementary/Secondary (0-12) College (1-4 or 5+) SH Be Father's Name (First, Middle, Last) 18. Mother's Name (Firşt, Middle, Maiden Surname ೨ tti I aa 0 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Carmichael 720 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other pa = 5 Department of Important: If any injury or once. 7.10.12 Landover, MD grmony Mem FREEMAN FONERAL SERVICES 2. Name and Address of Facility o Fune mo 20748 23a. Part 1. Enter the disease, of shock, or heart failure. Let of the mode of dying, such as cardiac or respiratory arrest. r complications that only one cause on t a used the death. Do not each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Duch disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the burial-transit The law requires that the death certificate be executed and Due to (or as a conseque resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IE EEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ been signed by the atter should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has performed 1 Yes 2 No No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be 2 No 1 Inpatient 2 🗆 1 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Many er of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ainer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse 3 Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur and title of c 29d, Date signed (Month, Day, Year,

State Registrar and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ eoRae SUNE Medical Facility Name (if not institution, give street and number or Location of Death 4c. County of Death **Examiner** more 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours (Month, Day, Year) Director 224-38-3834 1 🕱 M 2 🗆 F 79 0.3 13 33 MD ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 XYes 2 No Baltimore 10e Street and Number 10g. Citizen of What Country? items 23a Funeral 708 Brune Street 21201 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Page 1 and 2 should be new ...... front of Health and Mental Hygiene. from an arked other than "natural", or i' Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade Military Air Force Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Banks Horace Roy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 708 Brune Street, Baltimore, Md 21201 Martha Chapman Banks-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Remoyal from State injury o 4 Donation 5 Other (Specify) 7/2/2012 Owings Mills, Md Forest Vet son 21. Signature of Furral Servi 22. Name and Address of Facility
March Funeral Home (West) 4300 Wabash Ave Baltimore the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Epter shock or he Approximate heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph. sician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or injury that initiated events resulting in death) Last burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as ding IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Dav Year signed by the at d be detached for 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 : has autopsy performed death? 1 Yes 2 X No 25. Was case referred to medical examiner? **Division of Vital** 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 💢 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral to 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10NORTH GR Kes State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07 Physician/ 6530 atric ael Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore NIA 8. Date of Birth (Month, Day, Year) **Funeral** If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Days Hours **Director** 1 M 2 1 F items 23a or 28a-f show her must be notified at 10a, State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MI Baltimore 1 Ves 2 No ndsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2124 15 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. δ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced ac Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than 'e Elementary/Secondary (0-12) College (1-4 or 5+) 2 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, h and Mental H 7 is marked ot မ Health and Ment tem 27 is marked other traumatic Inornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) avid Jones Kd KandallStown item 2 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State o = 10 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place Department of Important: If any injury or 2012 4 Donation 5 Other (Specify) saltimore 21. Signature of Fulleral Service Li 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying o (or as a consequence of) Exami Cause (Disease or injury that initiated events resulting in death) Last disease been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Year Day Pregnant at time of death 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? φ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy After this certificate 2 🗌 No Yes 2 No 1 Yes the Hospital or Attending Physician: thin 24 hours after death. within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature 136001 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Mihae State Registrar

DHMH 17 Rev 06-2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2012

			101	-	epartment of Herenant of December 2015 Pertificate of December 2015		lental Hy	giene	
			State Registrar	112 20988					
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		<ol><li>Date of Dea Month</li></ol>		3. Time of Death Year		
gardenia.	Medic	al .	Francis J. Bees, Jr.				June 2	8, 2012	16:08 P <sup>M</sup>
	Examin	er	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or L  Berlin	_ocation of Death		4c. County o	
	Funeral		Atlantic General Hospital  5. Social Security Number   6. Sex   7. Age	(In yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Bird	h	9. Birthplace (State or Foreign
90	Director		214-40- 2864 x M 2 D F	Yrs	Months Days	Hours Min.	(Month, Da		Country)
	W 4			59	Lancting		July 12	2, 1942	Maryland  10d. Inside City Limits
	ryland -f sh ied al	cto	,	10c. City, Town or					1 ☐ Yes 2 ☐ No
	e Ma r 28a notif	Pire	Maryland Worcester  10e. Street and Number	Ocean_	10f. Zip Code			10g, Citizen of W	
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	14105 Sailing Road			1842		rog, Ortizeri or vvi	USA
	ems	Ĕ,	11. Marital Status 12. Was Decedent E	ver in U.S. 1	Was Decedent of His			14. Race	- American Indian,
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	iled w I Hyg othe ent,		17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,		
Maryland	should be filed within 72 n and Mental Hygiene. 7 is marked other than "r raumatic event, the Med	၀	Francis J. Bees. Jr.			Evelyn	V. Alve	ev	
[an]	shoul and i is ma		19a. Informant's Name/Relationship (Type, Print)	1	ailing Address (Street ar				
2	ealth m 27		James E. Bees Brother		<u>66 Cimarro</u>				21234
Baltimore,	Je 1a It of F If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, c	sposition (Name of crematory or other place	)	ate		City or Town, State
ţim	it. Pag rtmen rtant: njury		4 Donation 5 Other (Specify) Entombme	nt Most	Holy Redeer			Baltimo	re Maryland
Bal	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Funeral Service Licensee		22. Name and Address Leonard J. 5305 Harfo	Ruck,Ind rd Road	Baltim	ore MD 2	21214
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not e	enter the mode of dying.	, such as cardiac o	r respiratory an	rest,	Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition resulting in death)	uman	ca				Onset and Death
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	ted ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	,					
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Вох	e dea the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	time of death	5 Other (specify)			141011	III Day Tour
P.O.	ad by detac	y Ph	Part II. Other significant conditions contributing to death be	ut not resulting in the	ne underlying cause give	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
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alF	ian: T rtifica ctor, p		25. Was case referred to edical examiner?		26. Plac	ce of Death (Check		Z E INO	E 100 2 E 110
<b>Xit</b>	hysic nis ce il dire	일	1 Yes 2 No Hospital:	ent 2 🗆 ER/Outpa		4 Nursing Ho	me 5 🗌 Resid	dence 6  Other	(Specify)
ιof	ing P	ate:	27. Mann of Death  1 Natural 5 ☐ Pending  28a. Date of injur (Meath, Day,	y 28b. Time ; <i>Year)</i> injur	y work?		28d. Describe h	ow injury occurred	d
Sior	death death stor: / y the	Certificate:	2 Accident Investig 3 Suicide 6 Coul of be	ry - At home farm	M 1 L Y	∕es 2 □ No	28f Location (9	Street and Number	or Rural Route Number,
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П	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has I completely filled in by the funeral director, page 2 8	Medical	29a. Certifier 1 Oertifying Physician: To the best of r						
	the H nin 24 the Fu	Med	(Check 2 — Medical Examiner: On the basis of ex only one) 3 — Certifying Nurse Practitioner: To the	best of my knowler	dge, death occurred at the	e time, date and pla	ce, and due to t	he cause(s) and ma	anner as stated.
	5 wit		29b. Signature and title of certifier		29c. License	-		29d. Date signed	(Month, Day, Year)
	) .					3612		112	
	81		30. Name and address of person who completed cause of de	er MD	97-33 t	tealth	vay T	2 Ber	11815 am 211-
	Sta Registr		31. Date filed (Moorly Day, Year) 32 registra	r's Signature	harle		U		
			August 1						

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10-28-2012

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Bees, Francis J.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#11perFH, G929, 7/3/2012, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death stein Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 643 AM BERNARD BRAUNSTEIN Medical 2013 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ba (+) more Sinai Hospital of Ba (timave N/A if Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Country) Director 094-20-0655 1 X M 2 □ F 84 10/08/1927 0 Usual Residence of Deceden NY permit. Pege 1 end 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth end Mentel Hygiene.
Importent: If item 27 is marked other than "netural", or items 23a or 28e-f shown injury or other traumatic event, the Medical Examinar must be notified at once. 10b. County 10a, State 10c. City, Town or Location Director 10d. Inside City Limits BALTIMORE BALTIMORE 1 Yes 2 No Bernard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 18 TALTON COURT 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Never Married 2 X Married Black, White, etc. Completed by Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3. ₩idowed 4 Divorced Specify: Year or Dates WHITE 20 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 OWNER REAL ESTATE Kuowy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **ISADORE** BRAUNSTEIN BELLA SERAINIK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 W. WATER STREET, ELMIRA, NY EDWIN BRAUNSTEIN/SON Baltimore, Parfect 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) FRANKLIN STREET CEM : 07/02/2012 ELMIRA, NY 21. Signature of Funeral Service Light 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocadeal Physician/ IN euchou disease or condition resulting in death) cute Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): attending physician end I for use es the burlei-trensit or Attending Physicien: The lew requires thet the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day Year cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OND WEEK 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a, Was an this certificate has autons prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the I within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Gueco AES-000 Gerardo June 29,2012 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GINAL HOSPITAL OF BALTIMORE GERARDO 6 GUECO WO 31. Date filed (Month, Day, Year) JUL 0 3 2012 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ COURSEY Month LILLIAN 0 520 R. M Jun 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City N/A Good Samaritan Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 218-26-0268 Director 1 □ M 2**X** F July 15,1932 Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 ☐ No Baltimore City N/A 10e. Street and Numbe 10g. Citizen of What Country? Funeral 4920 Greencrest Road 21206 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 X No Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify 3x Widowed 4 □ Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 4 Years Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Margaret E. Stein Leonard E. Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Coursey (Daughter) 4920 Greencrest Road Baltimore, MD 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/3/2012 Hilltop Service Corp. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 WIN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Q unknown disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause (Disease or injury Due to for as a nonsequence of or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) signed by the atter d be detached for i in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director. After this certificate has been six completely filed in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Yes Hospital 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier June 29, 2012 000 18230 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samantan Horpital MD 21239 SHASHIDHARAN. LATHIL

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Kyra (ooper 6:26 P M June 26 2012 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 2311 Wheatley Dr. # Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 33 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days July 27, 1978 Country Hours Min 212-92-8178 Director 1 □ M 2 🕇 F Usual Residence of Decedent show 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director N/A Baltimore MD 1 🖾 Yes 2 🗌 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2311 Wheatley Dr. # 202 21207 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Specify: Black 1 Mever Married 2 Married δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (1-4 or 5+)
1 Yr Elementary/Secondary (0-12) Specialist Computers 12th Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Audrey M. Graves Audrey George R. Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600~W . Mt . Royal Ave #101 Balto , MD 21217 Audrey M. Cooper/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory 7/7/12 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) ignati f Fune 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balti., MD 21223 t 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physiciani uterine cancer Medical resulting in death) Due to (or as a consequence of): Examine Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or Light y that initiated events Due to (or as a consequence of) the attending physician and thed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant a Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\sum \) No 1 Tes 2 🗌 No 25. Was case referred to medical examiner? 8 B 26. Place of Death (Check only one) Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 ☐ Yes 2 ☑ No 횬 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) nslajapath(MD D0057465 6/29/12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NSRAMPARAMO TRS Smith TV STE Baltmore 5203

Registrar

State

JUL 0 3 2012

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 | 2 Certificate of Death Reg. No. Decedent's Name (First Middle Last 2. Date of Death 3. Time of Death Physician/ 2 Day 201 2 2 2 12:15 am Robert Wayne Carey July Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Belair **Examiner** 4c. County of Death 1307 F Scottsdale Drive Harford 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🙀 M 2 🗆 F 217-26-4345 (Month, Day, Year) 81 Director Feb. 18. MD Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any chart: If item 27 is marked other than "natural", or items 23a or 28a o 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Harford Belair MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1307 F Scottsdale Drive 21015 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Xes 2 No Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Beth Steel Supervisor <u> 12th</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Levada B. McDowell Walter D. Carey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1307 F Scottsdale Drive Belair MD 21015 19a. Informant's Name/Relationship (Type, Print) Carolyn Carey /wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State
Baltimore MD 1 🗆 Burial 2 🔀 remation 3 🗆 Removal from State Bayview Crematory 5 Other (Specify) 4 Donation 21. Signature of 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1 Enter the disease or commentations that caused shock, or heart failure. List only ole cause on each line Immediate Cause (Final ations that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Other (specify) Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29b. Signature ar

State Registrar

DHMH 17 Rev 7/2009

completed cause of death (Item 23a) (Type, Print)

TOR, MD 2014 TOUGATE RS

SPECTOR

BEZ AIR, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2012 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ 201<sup>°</sup>2 8:07 A Mildred L. Cooper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore 2017 Rayner Avenue If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. 89 Director 212**-**20-4054 Jamaica Usual Residence of Deceden 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State must be notified at Director MD NA Baltimore XX Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral USA 23a 21217 2017 Rayner Avenue Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 XNo Black, White, etc. African 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: American "natural", Completed 3XXWidowed 4 ☐ Divorced th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) City of Baltimore School Teacher 12th Grade Masters Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Smith Smith Berthena Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2017 Rayner Avenue Baltimore, Maryland item 27 i Mary Walker-Niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Arbutus Mem. Park 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 0 Department of Important: If any injury or 06-30-12 Arbutus, MD. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lense 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only or cause on each line. Immediate Cause (Final Onset and Death Physician/ EMPHYSEMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or illijury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY PERIPHERAL DISEASE 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of HYPERTENSION 24a. Was an autopsy page 2 1 Yes 2 7 1 ☐ Yes 2 ▼ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? 1 🗌 Yes 2 🗌 No iniury 5 Pending within 24 hours after death.

To the Funeral Director: Af Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 046071 My 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ESEGE

31. Date filed (Month, Day, Year) ...

4538

DHMH 17 Rev 7/2009

AVENUE

EDMONDSON

BACTIMORE

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			FOI	epartment of Health and N Certificate of Death	lental Hygier	ne		
			Registrar  1. Decedent's Name (First, Middle, Last)	No. 2 2 2 3 9 9 1				
	Physicia Medic		Shayla Nikkole Curtis	Bay 20 18:45 P M				
	Examin	_	4a. Facility Name (if not institution, give street and number)  Southern Maryland Hospital	c. County of Death Prince Georges				
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthound of the security Number 1 □ M 2X F	Months Days Hours Min.	8. Date of Birth June 23, Yea	2012 9. Birthplace (State or Foreign Marry Land		
	and show	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits		
	Maryk 28a-f otified	Director	MD Prince Georges Brand			1 ☐ Yes 2 🗓 No		
	ith the		10e. Street and Number 3575 Curtis Place	10f. Zip Code 20613	_	Citizen of What Country? USA		
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 X Never Married 2  Married If Yes 2 X No If Yes, Give	13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: black		
Maryland 21215-0036	72 hours an "natura Medical E	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of work e. DO NOT use retired)	ing 16b	b. Kind of Business/Industry		
212	within ygiene. ner tha t, the I	o Co	INFANT INFANT	INFANT		INFANT		
and	ntal Hyced oth	To Be	17. Father's Name (First, Middle, Last) unk		e (First, Middle, Maid Curtis—Ha			
Maryl	12 should be file lith and Mental I 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (Type, Print) Shayna Curtis—Hasan — mother	v or Town, State, Zip Code)				
Baltimore, I	age 1 and 2 ent of Healt it: If item 2 y or other		20a. Method of Disposition 20b. Place of I			c. Location - City or Town, State		
Baltir	permit. Page 1 a Department of H Important: If its any injury or ot	9	21. Signa are of Fona in Specify	22. Name and Address of Facility Sta	te Anatom St; Balti	y Board more, MD 21201		
			23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between		
24	tiyaldan!		Immediate Cause (Final disease or conditiona Extreme \frac{1}{1000}	ematurity		Onset and Death		
	Medical Examiner		resulting in death)  Due to (or as a consequence of)					
		iner	Sequentially list conditions, if any leading interpretate cause. Enter Underlying					
	cate be executed physician and s the burial-transit	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of					
0	be exe	edical E	d d					
8760	ificate ig phy as the	Medi	IF FEMALE:					
Box 687	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and real director, page 2 should be detached for use as the burial-trans	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown		23d. Date of delivery Month Day Year			
ls, P.O.	v requires that th s been signed by should be detact	ğ	Part II. Other significant conditions contributing to death but not resulting in		bacco use contribute to the cause of death?			
Division of Vital Records,	sician: The law requ certificate has bee lirector, page 2 shou	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  No 1 ☐ Yes 2 ☑ No		
tal	ysician: 1 is certifica director, p	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Chec				
of Vi	Physi r this c eral dir	2	1 Yes 2 No 1 Inpatient 2 ER/Out 27. Manner of Death 28a. Date of injury 28b. Til	ne of 28c. Injury at	ome 5 Residence 28d. Describe how in	e 6 Other (Specify)  njury occurred		
ou c	Attending Ph er death. ector: After th by the funeral	icate	2 Accident Investigation	work?  M 1 Yes 2 No				
<b>Jivisi</b>	al or Attending P s after death. I Director: After t d in by the funera	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	t and Number or Rural Route Number, tate)				
	the Hospital or hin 24 hours afte the Funeral Dir mpletely filled in	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, drope of the desired form of the basis of examination and/or Certifying Nurse Practitioner: To the best of my knowledge, drope of the desired form of the basis of examination and/or or o	investigation, in my opinion, death occurred a	t the time, date and pl	lace, and due to the cause(s) and manner stated.		
	To the within 2 To the comple		29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)		
			30. Name and address of person who completed cause of death (Item 23a) (T)	D00444 92		6/27/2012		
			30. Name and address of person who completed cause of death (Item 23a) (Ty	atts Pol. Clint	man no	20735		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature		,	-		
	Registi	ar	JUL 0 3 2012 Severe B. Sa	Kad				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Josefina C. Cobo Medical 2012 11:25 AM June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arcola Health & Rehabilitation Silver Spring Montgomery Funeral Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) **Director** 1 🗆 M 2 🔀 F 220-60-4520 84 July 8,1928 Cuba Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location with the Maryland be notified at Director 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2 X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 20906 901 Arcola Avenue United States and 2 should be filed within 72 hours after death. Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No or i Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 K Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Specify. Year or Dates Cuban White er than "nature the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Nail Technician Cosmetology Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked o traumatic eve ပ္ Francisco Cobo Maria Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marisa Schellin / Daughter 6320 Johns Lane Dunkirk, MD 20754 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 6/30/2012 Woodbine, Maryland 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the d. ease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Acute Stroke disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Other (specify) Pregnant at time of death Month Day Year 2 X No 9 Unknown 9 Unknown rate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension, Dementia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform death? 1 Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 A Residence 6 A Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural 5 Pending work Accident
Suicide 1 Yes 2 🗌 No completely filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) June 29, 2012 D45471 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) Yeheyis Negussie 1111 Spring St. #214 Silver Spring, MD 20910

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Louise D. Cornett 28 20127:00 AM June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 178 Cinder Road Timonium g. Birthplace (State or Foreign Country) West Virginia Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Month, Day, Months 1 M 2 X F Hours Year) 1917 **Director** 155-28-8261 Feb. Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at **Funeral Director** MD Baltimore 1 Tes 2 No Timonium 10e. Street and Number Ь 10f. Zip Code 10g. Citizen of What Country? items 23a 178 Cinder Road 21093 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ "natural", or 1 Never Married 2 Married ☐ Yes 2 🎇 No permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samue1 Boner Ethe1 Ha11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra L. Stevens/Daughter 178 Cinder Road, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 7/2/2012 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Departion 5 Other (Specify)
Signal of Final Senio Uce/see Dulaney Valley Memorial Gardens Timonium, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 Bryan W. Clary 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cordiac or respiratory, rrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or complication resulting 1 ath)

Due to (or as a consequence of): Approximate Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 N After this certific funeral director, 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 8c. Injury at work? 28d. Describe how injury occurred 5 Pending injury Natural s after death.

I Director: A in by the fu 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the causa(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29d. Date/signed (Morth MO

State

Registrar

30. Name and address of person who completed cause death (Item 23a) (Type, Print) 1447 York Rd., Lutherville, MD 21093 Robert Stoltz, M.D.

31. Date filed (Month, Day, Year) 32. Registrar's Signature Dark Suite 605

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death 8:17AM Physician/ Arnold Max Crouse Medical 4c. County of Death
Baltimore 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 70WS0r1 If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Months Min Country) Director 213-20-5819 1**火** M 2 □ F 87 8/29/1924 Maryland Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 28a-f 1 Yes 2X No MD Baltimore Glen Arm 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Numbe 23a Funeral 12400 Woodcrest Lane 21057 U.S.A. items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 XNo Specify: Specify: White 3 Widowed 4 X Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Men life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) High School Teacher Education 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Reynard 9353 Pan ridge Rd. Baltimore, Mp. 21234 ition (Name of Date 20c. Location - City or Town, State / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 Donation Other (Specify) Metro Crematory 7/3/2012 Baltimore 22. Name and Address of Facility Parkview Funeral 21. Signature Home & Cremation Service Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between JNKOUK Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) certificate be executed and burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ ō in the past 12 months? Day Year Month signed by the at d be detached for Yes 2 No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy has this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA ည funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work?
1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 4 Homicide determined

Box 68760 Division of Vital Records, P.O. Hospital or Attending Physician: s after death. filled in by the To the Hospital of within 24 hours a To the Funeral Completely filled

Baltimore,

Medical 29a. Certifier 29b. Signati

ddress of person who completed cause of death (Item 23a) (Type, Print) M.D. Evelius ohn

3

only o

29c. License numbe

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 3/2012

600 Osler Drive Suite 308 Towson Md 21204 31. Date filed (Month, Day,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month  $P^{M}$ Douglas Monroe Crane 2012 Medical 06 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice <u>Timonium</u> Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) Months Days Hours Min. (Month, Day, Year) 07/07/1947 1 ÅM 2 □ F Director 217-50-5108 64 Yrs. Maryland ed other than "natural", or items 23a or 28a-f shovevent, the Mudicial Evanting must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No MDBaltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 29 Pendragon Court 21136 Maryland 21215-0036 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Completed 3 □ Widowed 4 □ Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) q <u>Carpenter</u> <u>Carpentry</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any Injury or other traumatic ev 2 Oliver Crane Gladys Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne Davis / Sister 8202 Mitnick Road, Nottingham, MD 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 🔯 Cremation 3 🔲 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 6/30/2012 Beltsville, MD 21. Signature of Funeral Service Line 22. Name and Address of Facility Maryland Cremation Services, PO Box 1413 Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physiclan: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events attending physician and for use as the burial-tran the burial-trai Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 🗆 No 1 🗌 Yes eral Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No ျု 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Dea 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XX Natural (Month, Day, Year) 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and during the naturally and manner as statial only one 29b. Signature an 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) State 32. Registrar Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Month Year harles /Medical 2 7 20/2 07/84 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/13/1951 **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 □ F Months Days Hours 250-90-2227 Director 60 S.Carolina Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location shov 10d. Inside City Limits or 28a-f si notified Director Maryland Baltimore 1X Yes 2 □ No the 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö must be i Funeral 1202 Woodyear Avenue USA 21217 or Items Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner within 72 hours after Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2X If Yes, Give Year or Dates: 21215-0036 3 1 Yes 2X No Specify 3 Widowed 4 Divorced Specify: Black "natural", Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) filed within Hygiene. other than College (1-4 or 5+) Stock Clerk Food Lion 12th\_grade traumatic event. 17. Father's Name (First, Middle, Last) Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked Luther Dismel Lillie Mae David ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trains Lakia Dismel 204 Peoke Ave.Durham, North Carolina 27707 Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Woodlawn Cemetery 7/5/12 Woodlawn, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown RD.Baltimore MD.21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) thereschoole adjovación /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical as I dina IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? Pregnant at time of death Month Day Year 5 Other (specify) ed by the a 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed d be de 23e. Did tobacco use contribute to the cause of death? 3 2 should Completed 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed certificate 2 No 1 Yes 2 □ No 1 Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Physician: funeral director, Be 26. Place of Death (Check only one) Hospital: 1 - Inpatient Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation Director: After Injury 2 Accident М 1 Yes 2 □ No the 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 🗌 Homicide To the Hospital of within 24 hours a To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 27 20/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mai

DHMH 17 Rev 1/2001 11595

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 001 3ª 4:04 Medical Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death tos Battimore OWSO 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Months Hours Min. (Month. Day Director 1 🗆 M 2 🕅 F 50 or 28a-f show the Maryland 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No timore 10e. Street and Numbe 10f Zin Code 10g. Citizen of What Country? 2639 23a permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a 2/205 USA and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes Give Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working fre. DO NOT use retired)
UNSING ASSISTANT Segondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of Cemetery, crematory or other of Cemetery) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 12012 Baltimore, 4 Donation 5 Other (Specify) Signature of Euneral Service Licensee wit Baltimore 1101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ 5e95 e disease or condition resulting in death) Medical Due to (or as a consequence Examiner 0110 Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 h for use as attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death should be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown \ Var 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bade 2 s autopsy performed? Yes 2 No 1 Yes 2 No director. 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 🔼 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural work? 5 Pending injury Accident Suicide Investigation 6 
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 1007128 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shaheen N. Charles #4105 Baltimore 101 Sti 31. Date filed (Month, Day, Year) State Registrar